"More, better and faster..."

Confronting HIV, as well as Tuberculosis and Malaria: An Asia Stakeholders' Consultation

4-7 April 2006
New Delhi

Hosted by the Ministry of Health and Family Welfare, Government of India
Supported by the European Commission and the UNAIDS Secretariat
In partnership with the World Health Organization, CARE and the Confederation of Indian Industry

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNHCR UNODC
UNICEF ILO
WFP UNESCO
UNDP WHO
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Contents

Abbreviations

ACT	-	Artemisinin-based Combination Therapies
AIDS	-	Acquired Immuno Deficiency Syndrome
ANMs	-	Auxiliary Nurse-Midwives
ART	-	Antiretroviral Therapy
ARV	-	Antiretroviral
ASHA	-	Accredited Social Health Activist
AWW	-	Anganwadi Worker
BRAC	-	Bangladesh Rural Advancement Committee
CBO	-	Community Based Organization
CCM	-	Country Coordinating Mechanism
CD4	-	T helper cells (a type of white blood cells)
CII	-	Confederation of Indian Industry
CS	-	Civil Societies
CSO	-	Civil Society Organization
CSR	-	Corporate Social Responsibility
DDT	-	Dichlorodiphenyl trichloroethane
DOTS	-	Directly Observed Treatment- Short-course
DP	-	Donor Programs
EC	-	European Commission
ECTA	-	European Commission Technical Assistance
ELISA	-	Enzyme-Linked Immuno Sorbent Assay
EU	-	European Union
GF	-	Global Fund
GFATM	-	Global Fund to Fight AIDS, TB and Malaria
GIPA	-	Greater Involvement of People Living with HIV/AIDS
GTT	-	Global Task Team
GTZ	-	German Technical Cooperation
HIV	-	Human Immunodeficiency Virus
HLFPPT	-	Hindustan Latex Family Planning Promotion Trust
HRGs	-	High Risk Groups
H-T-M	-	HIV, Tuberculosis and Malaria
IDU	-	Intravenous Drug User
IEC	-	Information, Education, Communication
ILO	-	International Labour Organization
IRS	-	Indoor Residual Spraying

IT	-	Information Technology
ITN	-	Insecticide Treated Nets
ITPA	-	Immoral Traffic Prevention Act
LLTN	-	Long Lasting Insecticide Treated Nets
M&E	-	Monitoring & Evaluation
MARA	-	Migration Agents Registration Authority
MDG	-	Millennium Development Goals
MDR	-	Multi-Drug Resistant
MEDS	-	Mission for Essential Drugs and Supplies
MIS	-	Management Information System
MSF	-	Medecins Sans Frontieres
MSM	-	Men who have Sex with Men
NACO	-	National AIDS Control Organisation
NACP	-	National AIDS Control Programme
NGO	-	Non-Governmental Organization
NRHM	-	National Rural Health Mission
NTPC	-	National Thermal Power Corporation
OI	-	Opportunistic Infections
PEPFAR	-	President's Emergency Plan for AIDS Relief
Pf	-	Plasmodium falciparum
PHC	-	Primary Health Center
PSI	-	Population Services International
WHO-SEARO	-	World Health Organization-South East Asia Regional Office
SHG	-	Self-Help Group
STI	-	Sexually Transmitted Infection
SW	-	Sex Worker
SWAP	-	Sector Wide Approach
SWOC	-	Strength, Weaknesses, Opportunities and Constraints
SWOT	-	Strength, Weaknesses, Opportunities and Threats
TA	-	Technical Assistance
TB	-	Tuberculosis
TRIP	-	Trade-Related Aspects of Intellectual Property Rights
UN	-	United Nations
UNAIDS	-	Joint United Nations Programme on HIV/AIDS
USAID	-	United States Agency for International Development
VCCT	-	Voluntary Confidential Counseling and Testing
WHO	-	World Health Organization
WTO	-	World Trade Organization
YRG Care	-	Y.R. Gaitonde Centre for AIDS Research and Education

Executive Summary

HIV/AIDS, tuberculosis and malaria together kill six million people across the world every year[1]. The morbidity and mortality burden of these diseases is significantly high for Asia that accounts for more than 50 percent of global tuberculosis cases[2] and 22 percent of HIV/AIDS cases[3]. Malaria, though non-fatal in Asia, remains a significant problem, and is a cause of considerable economic loss for developing nations in the region. Since HIV/AIDS, tuberculosis and malaria are, to a considerable extent, concentrated in the same geographical regions, co-infection and interaction between these diseases have major public health implications. In this backdrop, "Asia Stakeholders' Consultation – More, better, faster: Confronting HIV, tuberculosis and malaria" was organized in New Delhi from April 4-7, 2006 to discuss issues and challenges, to share good practices, to review achievements and get a view point from all stakeholders.

The aim of the Consultation was to provide better understanding of the issues in the management of HIV/AIDS, tuberculosis and malaria. It drew over 300 participants from the Asian region; government representatives worked with disease experts, civil society organizations, corporate sector, members of several development partner agencies, persons living with the disease, private entrepreneurs and staff of international organizations. Expert groups deliberated on various issues and put forth their recommendations on the management of each of the three diseases, policy, financial and research issues.

On malaria program, the Consultation advocated convergence of regional approaches and adaptations to address the realities of the most-at-risk populations in order to provide universal access to prevention and care. It called for integration of malaria control in the national health programs, and investment in subsidies to provide better access to anti-malaria drugs, nets, better treatment literacy and a dependable supply chain.

The Consultation also noted with concern the lack of statistics on malaria mortality in the region, as without accurate data it may not be possible to design programs or earmark funds to fight the disease effectively. It emphasized the need for research to understand the extent of malaria infestation in the region, socio-economic conditions of the affected populations, customs, knowledge, belief about fevers, care-seeking behaviors, treatment and resistance patterns. It recommended improving health services in rural areas by providing training to private providers and village volunteers.

Asia carries the highest burden of tuberculosis in the world with more than 10 million cases. Three countries – India, China and Indonesia – account for half of the world's annual TB cases.[4] All countries in the region have national programs and strategies for the detection and treatment of tuberculosis. However, the issue in this region is of scale of services. This was addressed in the

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[1]http://www.theglobalfund.org/en/ as viewed on Aug 9, 2007

[2]http://www.searo.who.int/en/section10/section373_1339.htm#1, as viewed on Aug 9, 2007

[3]http://www.searo.who.int/LinkFiles/News_and_Events_Epicore2006_020ct06_en.ppt#3

[4]http://www.searo.who.int/en/section10/section373_1339.htm#1 as viewed on Aug 10.

recommendations through better use of decentralization of health services, better coordination between various elements of the health system, greater involvement of private sector providers, community empowerment, mobilization of community volunteers, and strengthening of the referral system. The Consultation noted that the approach to stop TB is efficacious, and no strategic change is required in the immediate future. The strategy however needs to be scaled up and tempo of efforts needs to be maintained for better outcome. The Consultation also noted the vital role played by community volunteers in the implementation, supervision and success of DOTS programs.

Deliberations on HIV/AIDS took the longest as it attracted the largest number of presentations and debates. The Consultation came up with a large number of recommendations on the issues. It emphasized the need for convergence and health system strengthening for better services in prevention, control and treatment of HIV/AIDS. It recommended replicating success stories of one program in another. The Consultation noted the advantages of involving people living with HIV in the prevention and control programs of HIV. This can be put to advantage in the management of tuberculosis. Conversely, the use of community volunteers for better access to treatment in tuberculosis could be successfully adapted for malaria care, and home based care for AIDS patients.

The Consultation emphasized the need for treatment education of patient, family and community. It recommended that health education be included in school curriculum and information disseminated through peer learning as well. It asked the governments to take ownership of malaria, tuberculosis and HIV/AIDS prevention and control programs as they have to see their long-term sustainability in making the services available to the poor. It also called upon governments to augment treatment services at hospitals. The Consultation recommended increase in the level of government funding for HIV prevention, care, support and treatment as it remains highly dependent on external support in most Asian countries. It suggested subsidized government-led social insurance system for the poor.

Under the policy issues, the Consultation underlined the need for geographic and socio-economic mapping of populations needing targeted interventions for any of the three diseases. This, it said, was necessary for targeting populations needing services most urgently, and was cost-effective in service delivery. It stressed that targeted interventions be tailored to specific needs of the communities. For the success of these interventions, the Consultation called for removal of obstacles that exist in the form of laws, government policies and regulations that alienate or do not recognize High Risk Groups (HRGs), stigma and discrimination that hamper delivery of interventions.

On the issue of scale up in services the Consultation recommended to start small, simple and low cost. It recommended that the services be first reached to the needy, and then integrated with the health system, as success in delivering the essential package is a prerequisite to expansion.

On legal reforms the Consultation recommended full implementation of national regulations on pharmaceutical registration, manufacture, quality control, procurement and distribution. In addition, it recommended specific measures to fight the menace of counterfeit drugs. It also underlined the need for reforms in the penal code of several Asian countries where same sex relations are considered a crime. As a result of such and similar provisions, the system does not recognize high risk groups such as sex workers, MSM and IDUs. This impedes and obstructs the reach of government intervention programs to the needy. It recommended legislative changes in such provisions through a process of discussions with all stakeholders and based on scientific evidence.

On regional cooperation, the Consultation recommended collaboration in research on vaccines and microbicides, cross-border strategies in prevention and control of the three diseases, partnership in population and development issues and joint initiatives in combating use of counterfeit drugs.

In its recommendations to the European Commission and other development partners, the Consultation recommended that they promote their support for the strategies that have proved effective in addressing the issue of marginalized groups at high risk of HIV transmission, and find ways to support community based approaches as these have proven efficiency. It also recommended that development partners support operation research in HIV, TB and malaria programs and disseminate its results. Such research would generate much needed evidence of the specific health care needs of different community groups.

It recommended that development partners link investment in infrastructure with public health goals, as it would facilitate better access for hard-to-reach areas. On investment in MDGs, the Consultation advocated that the EC and other development partners influence governments for sustained and improved allocations for health MDG, which have specific targets for the three diseases addressed at the conference. It recommended political advocacy to mobilize resources for malaria prevention and control, and for removing stigma and discrimination associated with tuberculosis and HIV/AIDS. It also recommended that the major development partners support national policies and align their programs with the national priorities.

Apart from these recommendations, the Consultation emphasized the need for integration of the 'big three' in the primary health care services. It recommended integration of laboratory services for early diagnosis, and policy reforms and enforcement mechanism to ensure minimum quality standards for all labs in the region.

In discussion on various issues the Consultation noted the advantages of community based approach. It recommended community based approach – equal participation of civil society organizations, community volunteers and patients – in program implementation as community involvement and ownership increases social mobilization and decreases stigma. It noted that community mobilization allows to specifically address some of the aspects of poverty and living conditions that represent specific tuberculosis risk factors. It also facilitates better knowledge of gender issues, and access to diagnosis and care for women. The Consultation also recommended use of new and available technology, like mobile phones and smart cards, to reach isolated, marginalized and high risk communities.

These recommendations would facilitate more, better and faster access to prevention, care and treatment of the three diseases to meet national, regional and global targets. These recommendations also show the way forward for integrating prevention, control, treatment and care of HIV/AIDS, malaria and tuberculosis in the primary health care systems in the region. Apart from this, the Consultation offered an opportunity to strengthen regional cooperation, and enhance Asia's contribution in the global fight against the three diseases.

Background

An **Asia Stakeholders' Consultation on Confronting HIV, tuberculosis and malaria,** hosted by the Ministry of Health and Family Welfare, Government of India, and supported by the European Commission and UNAIDS Secretariat, in partnership with the World Health Organization, CARE and the Confederation of Indian Industry, was held in New Delhi, India from April 4 to 7, 2006. The four-day conference saw participation of over 300 representatives of government and non-government organizations, multilateral and bilateral aid agencies, technical experts and grassroots workers from over 15 Asian countries.

The objectives of the Consultation were:

- To review achievements in AIDS, TB and Malaria control towards reaching global and country targets
- To present examples of innovative approaches and to share good practices and solutions that work in the prevention and management of these diseases
- To discuss systems that have proved to work, but also those that do not work, including health systems, governance and accountability systems, funding mechanisms, coordination platforms and systems to scale up towards universal and equitable access to good quality health services
- To discuss key challenges and gaps in terms of policies, strategies, good governance and accountability, fiduciary and implementation arrangements, management of strategic information, as well as partnerships for advocacy and research

Members from CARE's HIV Project perform a play during the opening ceremony

- To feed updated information into the policies and implementation strategies of national AIDS, TB and malaria control plans and programs in the countries involved in the Consultation
- To present the European Commission's Program for Action to Confront HIV/AIDS, TB and Malaria through External Action, and to consult with stakeholders on future action
- To discuss possibilities of strengthening regional cooperation, as well as Asia's contribution to the global fight against these three diseases.

The expected outcomes of the Consultation were:

Outcome One: Better Knowledge and Understanding

The Consultation will enhance the knowledge of participants and their respective institutions and constituencies on ways to ensure more, better and faster access to prevention, care and treatment, and therein to fight the three diseases more effectively and meet national, regional and global targets.

Outcome Two: Recommendations for Effective Integration and Convergence

Recommendations will be made on appropriate strategies for better integration of the three vertical programs into primary healthcare systems, and where integration is already in place, for increased and improved utilization of the existing systems.

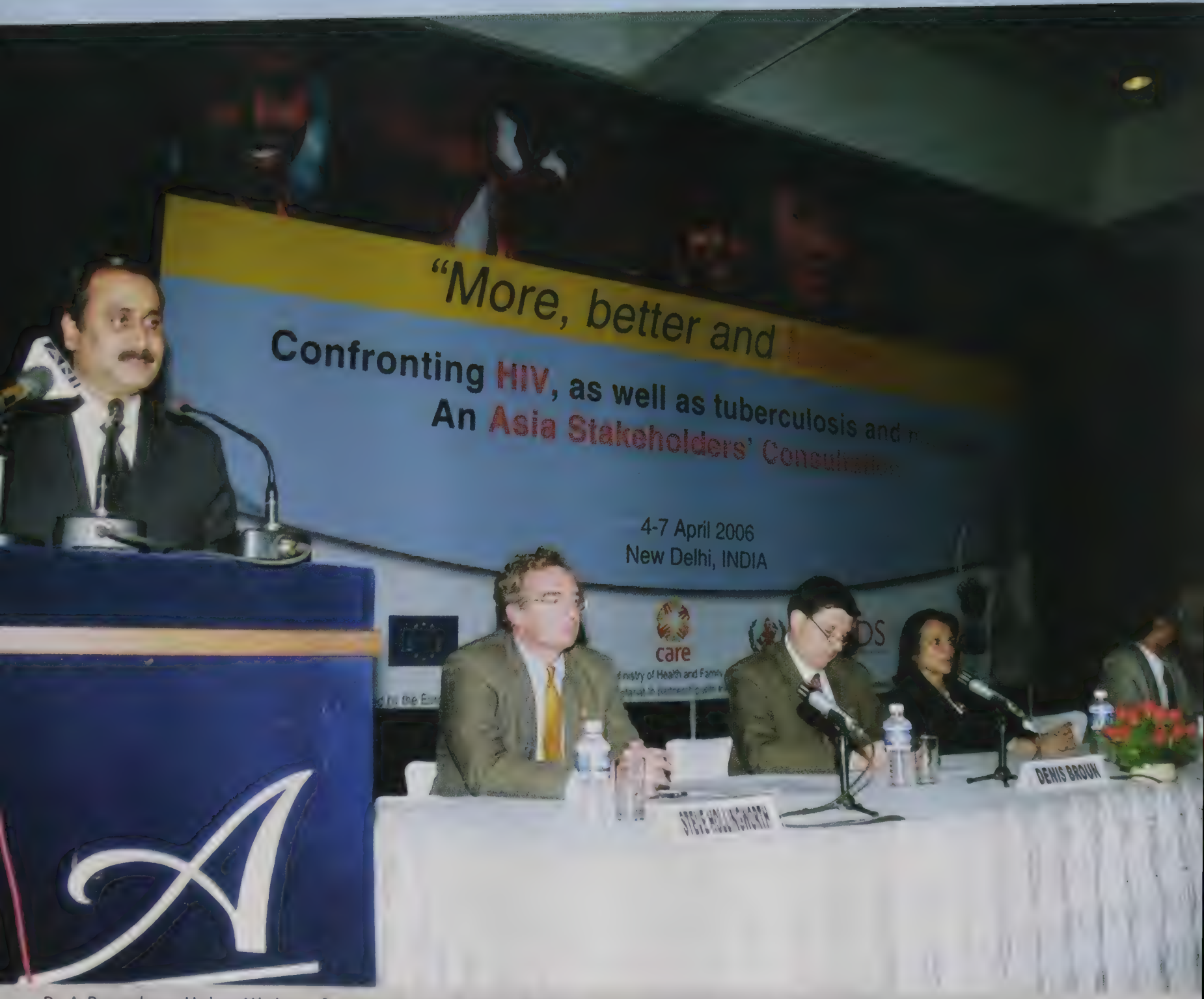
Outcome Three: Recommendations for Immediate and Future Action

Recommendations will be made for immediate and future action, to all concerned stakeholders and in particular to the European Commission and European Union Members States, within the framework of the European Program for Action to Confront HIV/AIDS, tuberculosis and malaria through External Action.

April 4

PLENARY 1

The Inaugural Session



Dr A Ramadoss, Union Minister for Health and Family Welfare, Government of India, addressing the inaugural session as Mr Steve Hollingworth, Director, CARE India, Dr Denis Broun, UNAIDS Country Coordinator and Dr Poonam Khetrapal Singh, Deputy Regional Director, South East Asia Regional Office, WHO, New Delhi, look on

The Inaugural Session

The Asia Stakeholders' Consultation on Confronting HIV, tuberculosis and malaria opened with the India's Minister for Health and Family Welfare, Dr Anbumani Ramadoss, exhorting the participants in his inaugural speech: "More, better and faster! That's what we need in tackling the 'Big Three' – HIV, TB and Malaria".

Describing the extent of these infections in India and Asia, as well as initiatives undertaken to address the arising problems, the minister highlighted the need for arriving at more accurate reports to determine the incidence, the need to approach issues of equity, access and delivery with specific focus on the needs of the poor, and the need to boost research, especially in developing vaccines.

Mr Deepak Gupta, Additional Secretary in the Ministry of Health and Family Welfare, Government of India, chaired the opening plenary, which began with a welcome address by Ms Rita Teotia, Joint Secretary in the Ministry of Health and Family Welfare, Government of India. In his keynote address, Mr Gupta emphasized the need for "more" funds and services, "better" communications for building awareness, providing treatment and care, and "faster" institution of all aspects of the continuum of care.

The need for 'more, better and faster' action in tackling the 'Big Three' was a constant theme in subsequent addresses by His Excellency Mr Francisco da Camara Gomes, the Ambassador, Head of Delegation of the European Commission (EC) to India, Bhutan and Nepal, Country Coordinator, Dr Denis Broun, the Joint UN Programme on HIV/AIDS (UNAIDS) and others.

His Excellency da Camara Gomes stressed that the EC, which has increased grants for healthcare programs worldwide four-fold between 2003 and 2006, is committed to releasing more funds for the sector, especially for more and better research, stating also that the EC supports promotion of generic pharmaceutical products. Referring to the Coherent European Policy Framework for External Action to Confront HIV/AIDS, tuberculosis and malaria, adopted by the EC in 2004, he emphasized that this was a significant step in that it evidenced that the EC, at its highest political level, is committed to confront the three diseases, with all its member countries adopting a common response to the challenge in all external action across all regions. Further, it is demonstrative of the leadership role of the EU in worldwide responses to the epidemics. "We remain committed to a balanced approach to prevention, treatment, care and support, and to a rights-based approach that focuses especially on the needs of the poor," he added.

The Ambassador of Austria in India, Her Excellency Dr Jutta Bastl, echoed the emphasis on "more, better and faster..." when she said that the EC is looking to step up aid to Asian development programs by 2010.

Dr Denis Broun defined the conference slogan when he stated that nothing short of universal access would meet the needs of Asia, adding that without this the financial loss arising from the three diseases to Asian countries would be an estimated US$ 18.5 billion.

Dr David Wilson of the World Bank in his insightful presentation emphasized the role of "sparks" in fueling the epidemics, drawing unexpected links between male circumcision, sex work, intravenous drug use and prison. He, along with others, stressed the need, especially at this stage of the debate, to focus on the evidence of what concretely matters, rather than on more general issues.

The EC Head of Development Cooperation, Mr Etienne Claeye, spoke of the EU Program for Action, which proposes collective EU action to support country-led programs to confront the three diseases as well as action at the global level in selected areas where the EU can add value. In this context, he specifically talked of the EC commitment to bringing down the prices of pharmaceutical products.

Presenting an overview of the prevalence of the three diseases worldwide, the World Health Organization Director of Communicable Diseases for Southeast Asia, Dr Jai Narain, pointed out that 96 percent of HIV incidence, just under 99 percent of malaria and 95 percent of TB are found in developing countries. Clearly linked to poverty and under-development – resulting from poor access to proper nutrition, adequate sanitation and other civic services as well as healthcare services, education, desperation and risk-taking behavior – these diseases aggravate poverty, he emphasized. Illness leads to loss of income, increased cost of disease management, decreased ability to manage household needs, including education of children, and often leads to homelessness, thereby leading to further marginalization.

The CARE India Director, Mr Steve Hollingworth, echoed these sentiments when he said that the "key commonality behind HIV, TB and malaria is indeed poverty". He went on to emphasize:
"It is important to see poverty as more than a lack of income, it is a structural and systemic marginalization and exclusion... Health solutions need to be based on sound technical approaches. They also need to provide a vehicle for addressing the structural and systemic barriers faced by the poor." Hollingworth elaborated on the underlying causes of poverty, saying that it is only by addressing these – the structural underpinnings of society, local, national and global, political, economic and social – that meaningful solutions to poverty and disease can be found.

"It is important to see poverty as more than a lack of income, it is a structural and systemic marginalization and exclusion... Health solutions need to be based on sound technical approaches. They also need to provide a vehicle for addressing the structural and systemic barriers faced by the poor."

Steve Hollingworth
CARE India

Reiterating the need for more, better and faster solutions to the issues of HIV, TB and malaria and the causes acerbating these, the Director of Confederation of Indian Industry, Mr N Srinivasan, pledged industry support to the effort, while Ms Helen Evans, Deputy Executive Director of the Global Fund to Fight AIDS, TB and Malaria (GFATM), described ongoing global initiatives to achieve results in that attempt. Mr P K Hota, Government of India Secretary for Health and Family Welfare, described ongoing efforts in India to address the issues, and emphasized the need for more resources, and better and faster implementation, concluding with a vote of thanks to the organizers.

April 5
PLENARY 2

Focus on Experiences and Perspectives

Ms K Sujatha Rao, Director-General, National AIDS Control Organisation (NACO), Ministry of Health and Family Welfare, Government of India, making her presentation

Focus on Experiences and Perspectives

Partnerships. Convergence. Scaling up. These were the key themes reiterated at the plenary on experiences and perspectives of various stakeholders, which was chaired by the European Commission Policy Desk Officer for Health, AIDS and Population in the Social and Human Development Unit, Mr Uwe Wissenbach.

Speakers at the plenary – the Additional Secretary and Director General, National AIDS Control Organisation (NACO), Ms Sujatha Rao, the Home Guards and Civil Defence Director-General, Dr Kiran Bedi, the Malaria Consortium Executive Director, Dr Sunil Mehra, representatives of private sector from Tata Steel, Jubilant Organosys Ltd and Hindustan Latex Family Planning Promotion Trust as well as Population Services International – covered a range of experiences spanning initiatives to prevent the spread of infection (as described in the efforts of the police and jail authorities under National AIDS Control Programme in India) and to create awareness (as with the private sector initiatives) to programs that address the cycle of prevention and treatment such as the malaria control programs worldwide and social marketing initiatives (as described by HLFPPT and PSI).

Status of the HIV Epidemic in India*

Statistical Profile

- 1986 – 1 person with HIV
- 2004 – 5.134 million persons with HIV
- HIV prevalence among adult population – 0.92%
- Prevalence in 111 districts – above 1%
- Feminization of HIV – women constitute 39% of all people with HIV
- HIV prevalence by age – 56.6% in the 30-49 age-group; 32.2% in the 15-29 age-group; 6.9% over 50 and 4.3% under 14
- Total number of AIDS cases reported to date – 1,19,445
- Transmission routes for HIV in India – 85.69% through sexual intercourse; 2.72% through peri-natal route; 2.57% through blood transfusions; 2.24% through intravenous drug use; 6.78% through unidentified means

Trends

The key factors aggravating India's vulnerability to HIV include high levels of poverty, illiteracy and poor awareness of HIV, its large, sexually active population and a large body of commercial sex workers and migrant workers.

The Government's priorities are to upscale HIV healthcare services, covering all high-risk population groups, decentralizing and focusing on the youth.

– From the presentation by Ms K Sujatha Rao
Additional Secretary and Director General, NACO

* National adult HIV prevalence in India is approximately 0.36% (between 2-3.1 million people) according to the new estimates, collated by NACO and supported UNAIDS and WHO.

The conclusions and suggestions that emerged from the presentations and discussions that followed are given below.

The experience of India shows the need for:

- A strong policy framework, focusing as much on prevention as care and treatment
- Strong partnerships among the government, civil society groups and private sector
- Convergence with national tuberculosis control and the reproductive and child health programs
- Integrated and stronger services that can be optimally effective.

On the ground, the experience of one NGO (working with the law-enforcement agencies) shows that what worked was:

- A transformational model, because it has longevity and acceptance, is cost-effective, scaleable, measurable and replicable, can become institutional by law
- Continued learning that raises self-worth, faith-based initiatives that foster healing and non-violence
- Enabling social integration.

The experiences of corporate bodies illustrated that not only can these organizations effectively educate and provide treatment for in-house staff, they can also play a significant role in extending such services to the community outside – e.g. through distribution of condoms among truck drivers and cleaners. They also inspire other commercial bodies to participate in such initiatives.

The experiences in social marketing in different countries demonstrated the importance of branding, quality assurance, providing customized products and solutions for target groups, creating and training a cadre of committed professionals, monitoring and networking, leveraging potential and strategizing for reaching the under-served.

The prime focus in the discussions was the issue of laws that stipulate same-sex intercourse and commercial sex activities as criminal in nature. Participants recommended that this must be reviewed, if HIV control strategies are to be properly implemented. Ms Sujatha Rao said, India's Ministry of Home Affairs is considering amending laws that declare sex work and same-sex activity as illegal. On the issue of homosexual rape, it was emphasized that this could be addressed only if consensual same-sex activity is legalized.

Preventing Malaria

Malaria is one of the most "neglected" killer diseases in Asia, a disease to which children are especially vulnerable. With vaccines for malaria not yet available, and chemo-prophylaxis being both expensive and too complicated for general compliance, vector control is proving to be the best means of malaria management and prevention. Indoor residual spraying (with DDT) has proved to be effective. However, this should be selectively targeted. The choice of insecticides must be carefully considered, especially in the context of vector resistance.

WHO and other experts advocated that "protection from mosquito bites is the best option" for prevention, and that insecticide-treated mosquito nets are among the most effective means to do so. In Myanmar and Cambodia, social marketing interventions have successfully introduced insecticide-sprayed mosquito nets.

Source: Dr Sunil Mehra, Malaria Consortium

Breakout Group Discussions

Group 1: Policy and Legislation

The discussion was based on presentations on 'Legislation for the Rights of Marginalized, Infected and Affected Groups – A Proposed Bill' and 'Workplace Policies in Practice'. While the former dwelt on the draft legislation prepared and submitted by an NGO, Lawyers' Collective, to the government, the latter was drawn off from the experiences of the International Labour Organization, the experiences of the Salgaocar Group of Goa and of Modicare Foundation.

The prime focus in the discussions was the issue of laws that stipulate same-sex intercourse and commercial sex activities as criminal in nature. Participants recommended that this must be reviewed if HIV control strategies, are to be properly implemented.

The Consultation process leading to the proposed HIV bill drafted by the Lawyers' Collective began with the NGO being assigned the task by NACO, and involved extensive and intensive dialogue Consultations with people with HIV, homosexual groups, sex workers, intravenous drug users and other marginalized population groups, healthcare workers, functionaries of state AIDS control societies, UN agencies, corporate and commercial organizations, employee unions, women's organizations, other civil society bodies across the country and the UN agencies concerned. The draft that has resulted is rooted in a rights-based approach. Drawing upon the "inextricable link" between HIV and human rights, it points out the limitations of relying on common law. It proposes legal measures to address issues of discrimination, informed consent, the right to confidentiality, privacy and stipulations for disclosure, right to access treatment and conditions for risk reduction, among others.

The discussion that followed dealt with a range of issues from which recommendations were drawn at each step. The need for information, as well as education and sensitization, was highlighted in the context of law making and implementation (where local or provincial laws are often contrary to national law), specially when vulnerable groups such as migrants, commercial sex workers, men who have sex with men, intravenous drug users, refugees, among others, do not enjoy the same legal rights as others, thereby aggravating their vulnerability to 'The Big Three'.

Workers in the non-formal sector are also a particularly vulnerable group. It was suggested that while corporate organizations are able to undertake healthcare programs in-house, the government, in partnership with civil society and multilateral organizations such as ILO, could

Framework of the HIV Draft Bill

CHAPTERS

Rights	Social Security
Prohibition of discrimination	Information, education, communication
Informed consent	Health ombudsman
Disclosure of information	Penalties
Access to treatment	Institutional/Healthcare workers' obligations
Duties of state	Safe working environment
Special provisions	Reduction of risk
Special procedures in Court	

RULES

REGULATIONS

– From the Lawyers' Collective presentation

institute mechanisms to provide health education and other healthcare services to the small enterprises that constitute the non-formal sector.

There was also forceful emphasis on the need for gathering and disseminating evidence. This was argued especially in the context of mapping migration as well as the performance of diagnostic and treatment centers, and of establishing what works and doesn't (for example, in the context of harm reduction).

It was also suggested, without elaboration however, that donors should institute joint missions. Subsequently, there was debate and strong agreement on the need for "local ownership".

Group 1: Policy and Legislation
Recommendations

Replicability and Adaptability

- Any legislation applicable to HIV and other related diseases should have a consultative process: full participation of all stakeholders at every stage, e.g. civil society and government. (Lawyers' Collective draft HIV bill on HIV.)
- Any legislation/policy should be based on sound scientific evidence. Laws and policies should be based on evidence demonstrating efficacy of harm reduction, e.g. needle and syringe exchange programs. (Example of best practice: Iran judicial decree endorsing harm reduction as health strategy).
- In the workplace context a committee, policy and program are required for implementation and sustainability.
- Workers, employers, government, trade unions, civil society should all be involved.
- Sector-specific approach.

Going to Scale

- Using existing platforms to reach out to larger numbers, e.g. families, trade unions and the communities in which they live.
- Ensuring that vulnerable communities are protected under legislation/policy, e.g. migrants, refugees, non-formal sector.
- Small enterprises need government and civil society support.

Partnerships and Relations

- Expanding partnerships between local communities and law enforcement in the harm reduction context.
- Expanding partnerships between People Living with the disease (HIV,TB or malaria), local communities, public and private sectors.

Integration and Convergence

- Bring in legislation that covers both formal and non-formal sector.
- Mainstream with other government programs, e.g. harm reduction merging with larger drug demand reduction programs.
- Supplement with advocacy, sensitization and social change.
- Harmonize policies across sectors and region.
- Harmonize laws across borders.

Decentralization

- Decentralize implementation but ensure state legislations are in harmony with national policy.

International Donors and Multilateral Institutions

- Role for international organizations in creating and replicating model policies, e.g. ILO on workplace policies.
- Strengthening coordination among donors to fill the gaps.

Group 2: Malaria Prevention

The discussions began with presentations on 'Options for Prevention: Beyond Bed-nets', 'Using DDT in Public Health: Policy and Impact' and 'Accessing Hard-to-Reach Populations'.

While the harmful effects of DDT in agriculture have been established, it is still useful for malaria control. The aim of malaria control programs is to accelerate research for developing safe, effective, affordable alternatives, and reduce reliance on DDT.

A WHO Expert Committee, after considering the reported studies on association of DDT and human cancers and breast-milk contamination, suggested that DDT could be used if all the following criteria are met:

- Should be used only for indoor residual spraying;
- Should be manufactured to WHO specifications; and
- Precautions should be taken for safety in use and disposal.

– AP Dash, National Institute of Malaria Research, ICMR, New Delhi

The options currently being studied for prevention 'beyond bed-nets' include chemo-prophylaxis, integrated vector control management and development of vaccines. Also under consideration are measures involving community participation based on awareness of integrated vector-control management across sectors. Detailed description of the experience of the Mekong Malaria Initiative Project implemented in areas of Southeast Asia along the Mekong river – Thailand, Vietnam, Cambodia, Laos, Myanmar and China – showed that key among the various factors that keep minority ethnic groups living in remote areas out of the healthcare service network are inaccessability of location, language, poverty, migratory habits, customs and beliefs on the one hand, and official policy on the other which, in most countries, consists of mainstream strategies not suitable to minorities either economically or culturally. The Mekong initiative has tried imaginative approaches to reach remote habitats, chief among which are the location of facilities within the area of the target population, and the recruitment and training of local people to provide preventive and testing services.

During the discussion, participants described experiences of malaria control programs in Afghanistan, Thailand, Laos, Myanmar, the Philippines (the Palawan Movement Against Malaria), Yemen, Togo and Niger. There was general agreement that across international borders, malaria

Kieran Daly, International Council of AIDS Service Organizations (ICASO), Canada raises a point during the group discussion

control (or any health-related) project has to deal not just with nomadic people and their customs, but also with complications arising from the presence of illegal migrants, smugglers, border security and armed forces.

The efforts of Doctors without Borders, an international organization, were described as innovative in addressing the needs of marginalized and remote communities as per their needs and customs, rather than trying to get them to access mainstream systems.

During the discussion on cross-border malaria control projects, a question was raised about rules of procedure and conditions where two or more countries wanted funding for a common cross-border project. While some donors, such as the Global Fund, have clear rules about this, it is for participating countries to dovetail their applications and ensure cooperation in the planning and implementation.

The Consultation emphasized the need for bordering countries to agree on a common healthcare program along border areas. This would also apply to provincial borders within a country, where provinces (or states) have autonomous powers for formulating healthcare policies.

It was also suggested that public-private partnership could be effective especially in the areas of funding or sponsoring healthcare projects and the manufacture and supply of equipment and drugs.

Group 2: Malaria Prevention
Recommendations

- Clear estimation and forecasting for LLTN requirements, and Long-term Commitment from donors to support its purchase, production and supply.
- Donors to spell out clear rules for cross-border projects (regarding application procedures, funding and implementation).
- Recognition that ethnic minorities are the most neglected, among the hardest to reach populations and highest risk group for malaria in Asia.
- Long-term commitment from donors in support of activities.
- Greater public-private partnership:
  - sponsorship by corporate, Shell in the Philippines
  - collaboration with industry partners who manufacture necessary materials, e.g. nets
- Regional networks to share information and training, e.g. ACT Malaria.
- Creation of a sustainable retail market through social marketing in some settings.

Other recommendations were:

- All malaria programs should have a component that targets ethnic minority groups and addresses malaria issues in border areas.
- Better and faster disbursement of funds.
- Increased collaboration with NGOs to improve the focus (and quality) of program activities in remote areas while the national program works on increasing resources for malaria control. NGOs should enhance the work of the national program and not setup parallel structures.
- Public-private partnerships are important; policies should be evolved on how to link the activities of private partners to the national programs.
- A shift from vertical to integrated disease management is required.
- Program managers should have a clear strategic direction with clear policies and guidelines, so that other partners are definite about where and how they can work together.

Group 3: Population Groups at Higher Risk: Access to Services

The session started with presentations on 'Increasing Demand from Sex Workers for Prevention', 'Increasing Demand for Prevention Services from 'Men who have Sex with Men' and on 'Engagement of the Police'.

The key arguments regarding services for prevention of HIV infection among sex workers were that:

- A short-term approach cannot address the issue effectively.
- Trafficking and prostitution have to be seen as two different processes; otherwise, violation and abuse will increase.
- Sex workers trained in counseling can play an important role in HIV prevention.
- The human rights of sex workers must be emphasized to counter the existing law, which makes their work illegal.
- Confidentiality is essential for sex workers to access treatment for HIV.

The key arguments regarding services for prevention of HIV infection among men who have sex with men were that:

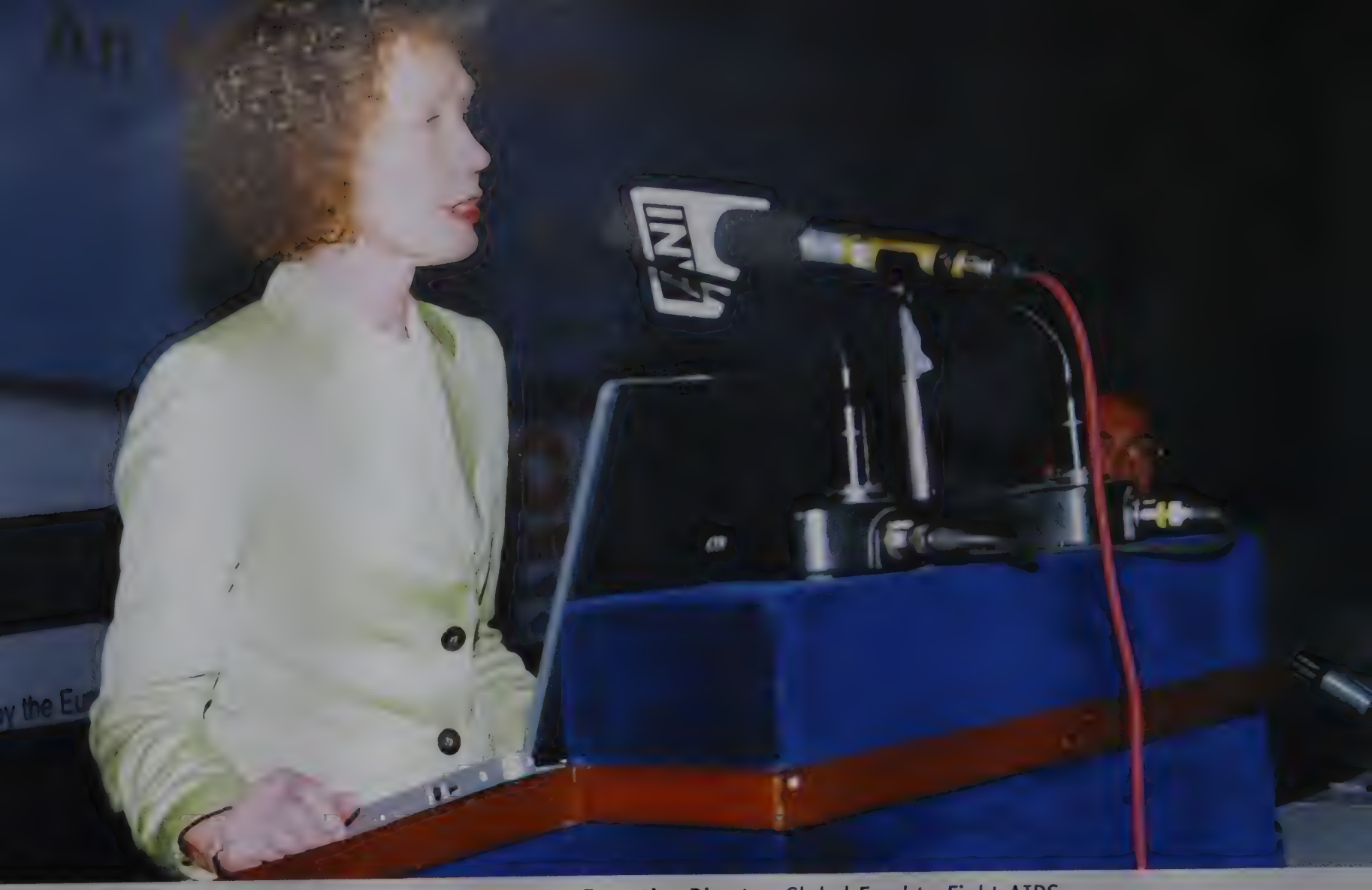
- Men who have same sex intercourse are invisible and 'underground' and therefore largely excluded from services.
- The existing law and policy push them further underground. It is imperative to make homosexuality legal.
- Violence against men who have sex with men continues throughout Asia.
- Homosexuality is illegal in many Asian countries; police use brutality towards homosexual men.
- Addressing the need for HIV prevention and treatment services for homosexual men is a crucial part of an HIV prevention strategy, but men who have sex with men are refused access to treatment and prevention tools like condoms, as for example, in prisons.

Strongly emphasizing the need for harm-reduction initiatives, the key observations regarding factors impacting services for intravenous drug users were that:

- The Narcotic and Psychotropic Substances Act has many imperfections.
- The police find it difficult to incorporate contemporary ideas and concepts.
- Prison authorities are hostile towards drug users.
- Vested interests are involved in the sale of drugs.
- Linkages between intravenous drug users, sex work and criminal activity are strong. Users take to crime and to sex work to sustain their addiction. Petty crimes by drug users, not involving violence, top the chart for incidence of crime.
- Police have a predisposed mindset that sees drug users as criminals.
- Prison authorities are not equipped to handle withdrawal symptoms among prisoners.

Participants emphasized that the present political climate is the real obstacle to ensuring HIV prevention services to vulnerable population groups. Referring to the USAID requirement that NGOs working with sex workers should sign a pledge against prostitution, they said such a move encourages prostitute bashing. Even the Global Fund does not entertain organizations that work for the rights of prostitutes. The EC, having gone through the morality debate about a decade ago, is increasingly granting the human rights of sex workers.

Subsequent discussion centered mainly on vulnerable groups like truckers and migrant laborers and on sensitizing law-enforcement personnel. Participants also said that prevention, care and support become difficult due to high prevalence of hepatitis B and C, in which cases antiretroviral therapy does not work effectively.



Ms Helen Evans, Deputy Executive Director, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), addresses the gathering

It was suggested that:

- Information dissemination as well as safe sex tools such as condoms should be distributed freely among truckers and migrant workers.
- Management of sexually transmitted infections (STIs) may be feasible through mobile clinics and referral centers.
- NACO should have a dialogue with the Home Department to amend laws such as the Immoral Traffic Prevention Act (ITPA).
- Donor funds should be given directly to organizations of sex workers because, through the conventional route, only a small portion reaches the target group.
- Sex workers "don't want sewing machines, but ... human rights", as a former sex worker put it.
- Community-based approaches work.
- There should be greater sharing of learning experiences.
- Vulnerable groups should be brought into the mainstream; NGOs should help such persons find work.

Group 3: Population Groups at Higher Risk: Access to Services
Recommendations

Obstacles

- Laws and policies: Change the law to recognize vulnerable groups and ensure their rights
- Advocacy: Changing mindsets, involves all levels of hierarchy
- Working with authorities
- Integration and convergence of stakeholders
- Donor requirement for funding too cumbersome
- Lack of funds for capacity building
- Competing for limited resources by various vulnerable groups
- Lack of appropriate strategy in taking advantage of FBOs as a potent resource
- Tokenism
- Invisibilized

What Works

- Integrating services into existing systems
  Example, Reliance intervention with truck drivers and migrant labor
- Peer intervention
- Prevention linked with treatment
- Adapting guidelines to local conditions
- Sustained partnerships
- Exposure visits and study of best practices

E.g. Myanmar to Kolkata

- Empowerment of vulnerable groups by giving them status of workforce/ILO,Thailand

More, Better, Faster

- Enabling environment
- Legalities, laws policies
- Upscaling
- Societal/cultural changes
- Issue of conflict/post-conflict situations

Group 4: Protecting Vulnerable Populations from TB

Three presentations triggered the discussion – 'The New Stop TB Strategy: Access for All', 'Preventing TB in HIV Patients: IPT (INH Preventive Therapy) and Beyond' and 'Intensified Strategies to Find Cases'.

Together, the presentations, which also included detailed descriptions of the experiences in Indonesia and Thailand, emphasized:

- The need for universal access: A narration of the success of 10 years (1995-2004) of the Directly Observed Treatment – Short-course (DOTS) program as also the strategies of several countries to achieve full coverage pointed out that 21 million patients have participated in DOTS over the decade, which ended in 2004. Asia (with India and China accounting for over a third of the 9 million new cases every year) and Africa, however, continue to see an increase in the incidence of TB, much of this related to HIV infection.
- The WHO-recommended Stop TB Strategy that focuses on expansion and ensured quality of the DOTS program through strengthening the public healthcare service system and including additional components such as the integrated service delivery for TB and HIV, highlights the need for political commitment, standardized treatment benchmarks in service delivery, efficient monitoring and regular drug supply.
- For effective TB control, special care of persons with HIV and coordination between the TB and HIV care structures are needed. Clear objectives, political commitment, capacity building, monitoring and evaluation are all needed for universalizing access through policy implementation.

- Reaching services to vulnerable populations involves collaboration with community-based organizations, stepping up DOTS implementation in slum areas, prisons and among refugee populations, incorporating TB care services in HIV treatment, in maternal health care and among young children.
- Improved governance and an effective, decentralized institutional environment are critical to effective health service delivery. This would include ensuring proper and transparent resource allocation, prioritizing programs and financial allocations with equity, and ensuring accountability. Private sector participation should also be optimized.

In the discussion that followed, participants raised several issues based on the experiences across India, Indonesia, Thailand, Bangladesh and the Philippines. The common problems included:

- The lack of equity in providing services to marginalized groups such as migrant workers, and also to vulnerable groups such as women and children.
- Access to services is especially weak in urban areas, particularly urban slums. This is true of all the countries. One participant noted the success of an intervention in India targeting truck drivers, sex workers and migrant workers, where messages regarding HIV and TB were given in an integrated packet.

Participants stressed the need to pressurize professional associations to make the existing public health system more accountable. In addition, they had the following recommendations:

- Private hospitals should adopt 'international standards of care' and make appropriate referrals to the public facilities.
- Improving the working conditions of healthcare workers would go a long way towards improving the quality of services they provide.
- For increasing awareness and adherence to therapy, community participation would play a critical role through peer education and community care groups, which would include diverse local stakeholders.
- For adaptability, replication and scale up.
  - Analyze and document what works;
  - Special attention to needs of migrants; also, mapping of migration patterns and seasons, and harmonization between healthcare services at entry and exit points;
  - Strengthen referral mechanisms, including referral between different levels of healthcare provision;
  - Map the status of the program;
  - Ensure that all hospitals implement the national policy;
  - Strengthen links between providers and communities;
  - Improve collaboration among TB, HIV and other healthcare services;
  - Establish standardized reporting formats;
  - Improve information, education, communication (IEC);
  - Empower patients and involve communities; this would also address issues of stigma;
  - Develop operations research protocols focussing on health service delivery in diagnostic and treatment centers to evaluate the competency of personnel, quality of services and reasons for non-performance; such research should include gender-disaggregated data, including data on utilization pattern;
  - Ensure better coordination among different

Access to services is especially weak in urban areas, particularly urban slums. This is true of all the countries. One participant noted the success of an intervention in India targeting truck drivers, sex workers and migrant workers, where messages regarding HIV and TB were given in an integrated packet.

healthcare providers through referrals and regular meetings, especially in the urban areas, and
    - Involvement of workplaces, particularly in urban areas.
- For partnerships, integration and convergence:
    - Hold consultations with all stakeholders;
    - Ensure improved partnerships with professional groups (doctors, nurses, midwives, etc);
    - Motivate local politicians;
    - Decentralize services and administration;
    - Disseminate evidence of what works and what doesn't;
    - Ensure availability and rational use of drugs;
    - Build human resource capacities, and
    - Ensure improved working conditions for healthcare providers.
- For donors and multilateral institutions:
    - Ensure country leadership in health programs; countries must remain in the driving seat and set their own priorities rather than be dictated by donors and multilateral institutions.
    - Harmonize funding in line with national policies and plans;
    - Establish standardized and integrated reporting systems to avoid duplication; and
    - Coordinate monitoring missions of donors and technical agencies.

Ensure better coordination among different healthcare providers through referrals and regular meetings, especially in the urban areas.

Finally, participants emphasized that critical items in health programs should be funded through country budgets rather than by donors to increase sustainability and ownership of the program.

A participant poses a question to Dr Nils Billo, International Union Against Tuberculosis and Lung Disease (IUATLD) during the working group session on TB

Group 4: Protecting Vulnerable Populations from TB
Recommendations

Replicability and Adaptability

- Analyze and document what works
- Migration identified as a common problem requiring special attention
- Mapping of facilities (migration patterns)
- Referral mechanism to be established and strengthened
- All hospitals (public and private) must implement the policy
- Mapping with status of involvement
- Abiding with program policies
- Link with community-based services

Going to Scale (1)

- Collaboration between TB and HIV and other services to be strengthened
- Referral systems to be clearly defined
- Standardized reporting formats
- Strengthen links between community and health providers
- Improve awareness and utilization through IEC (adapted to local setting)
- Provider-community, provider-patient interactions to be strengthened
- Address stigma

Going to Scale (2)

- Analyze performance of diagnostic and treatment centers
- Quality of services, reasons for non-utilization,
- Adequate personnel, attitudes and competence
- Patient empowerment
- Committees at village level that include patients, local leaders and other representatives of the community
- Gender – issues of access and utilization by women
- Operations research to identify utilization patterns

Going to Scale (3)

- Urban areas
- Better coordination between different providers (regular meetings)
- Strengthen and formalize referral mechanisms
- Improve management capacity among service providers
- Involve workplaces
- Operations research to involve communities in urban areas

Partnerships in Service Delivery

- Regular stakeholder consultations
- Improve partnerships with professional societies (doctors, nurses, midwives, pharmacies, etc.)
- Ensure commitment at all levels
- National, sub-national, community
- Motivate local politicians/leaders to understand the impact of TB in their communities

Integration, Convergence and Decentralization

- Guarantee quality of services during decentralization process
- Quality pre- and in-service training
- Disseminate evidence of what works and what doesn't
- Improve management capacity to ensure availability of drugs and services at all levels
- Rational use of drugs
- Build and retain human resource capacity
- Improve working conditions for healthcare providers

International Donors and Multilateral Institutions

- Donors should support country leadership
- Countries set priorities
- Harmonize donor contributions in line with national policies and plans
- Establish common and standardized reporting systems to donors
- Coordinate monitoring missions of donors and technical agencies (not more than 2 per year!)
- Sustainability
- Critical items be in country budget rather than be donor funded

Group 5: Advocacy

The session began with presentations on 'The Importance of Political Advocacy', 'Media's Role in Advocacy' and 'Empowering High-risk Groups for Community Activism'.

Empowering high-risk groups involves providing (non-formal) education and making a cultural space available to sex workers and other marginalized groups to express themselves. Describing the experience of sex workers in Sonagachi, Kolkata, it was pointed out that education had so empowered the sex workers that they started their own micro-credit and cooperative banking systems, thereby reducing economic vulnerability.

The argument on the importance of political advocacy began with the dramatic statement that malaria is a silent killer, so silent that the accurate number of those infected, affected, killed by this disease remains unknown. It emphasized that political advocacy must be local, national and global ... advocacy brings about acceptance of reality. The need to send a unified message, instead of divergent and often contradictory ones, was also highlighted, as was the argument that media coverage often determines the extent of political advocacy (and also donor funding) on the issue.

Describing specific media campaigns on social issues, the presentation on the role of media in advocacy stressed the need for coherent messages as also technical rightness. A survey of viewers in India showed that over 80 percent people learnt new information concerning HIV through television programs. Greater use of radio was also emphasized since it is the most widely used mass media form.

Empowering high-risk groups involves providing them (non-formal) education and making a cultural space available to sex workers and other marginalized groups to express themselves. Describing the experience of sex workers in Sonagachi, Kolkata, it was pointed out that education had so empowered the sex workers that they started their own micro-credit and cooperative banking systems, thereby reducing their economic vulnerability. However, it was also pointed out that the process of making sex workers active stakeholders in civil society mechanisms had still not resulted in any political change or increased funding for sex workers' organizations. Sex workers continue to be regarded as "a problem to be addressed in a humane manner".

In the discussion that followed, participants voiced the opinion that malaria is no longer as silent a killer as it used to be. They also said that there is a direct link between media coverage of health issues, and perceptions of the disease and the infected people, stressing that media is frequently gender insensitive and ridden with discriminatory mindsets.

It was recommended that:

- Journalists be sensitized. The media should regularly inform the public about 'evidence-based' successes.
- Compulsory sexual education in schools would not only provide protection to youth, it would also help address illogical and discriminatory attitudes to sexual minorities and other marginalized groups such as sex workers.
- Advocacy should be an integral part of all healthcare programs.
- Greater and more specific evidence is needed to show how direct funding of NGOs leads to more cost-efficient and better results.

Group 5: Advocacy
Recommendations

1. Replicability

- Document both oppressed and oppressor perspectives, so that the oppressed have a greater idea of the chasm between what is promised and done.
- Disseminate data on successes.
- For advocacy use media with widest reach, e.g. radio.
- Go back to communities and use their mechanisms to disburse information.
- Advocate with the police and parliamentarians.
- Organize workshops/training for media and other stakeholders, including parliamentarians, to sensitize them about various aspects in the prevalence of HIV, TB and malaria.

2. Scale

- The load burden should be used to advocate going to scale.
- Target specific vulnerable populace.
- Bring out consequences of not scaling up.
- Use the evidence of costs and economy to advocate for increased scale.
- Use a rights-based approach while going to scale.

3. Partnerships/Relationships (including ownership)

- Use regional partnerships (across regions of Asia) to push case, as the problems are similar.
- Be open to external agents of change.

4. Integration/Convergence

- Find common points regarding TB, malaria, and HIV, build united advocacy.

5. Decentralization

- Advocacy for civil society to be allowed to take responsibilities in prevention and control.

6. Donor Relations

- Donors having different specializations could teach each other.
- Donors must fund advocacy in Asia.
- Donor priorities need to be better coordinated.
- Funding should not be too vertical – leads to inefficiency. Health system strengthening needs funding.
- Evidence-based funding, to reduce discrepancies.

April 5

PLENARY 3

Round-up of Group Work

Dr Ruben F. del Prado, UNAIDS Deputy Country Coordinator for India chairing a meeting

Round-up of Group Work

Chaired by the UNAIDS Deputy Country Coordinator for India, Dr Ruben F. del Prado, the session had each breakout group presenting recommendations (given earlier in boxes at the end of each group discussion in the previous section).

The following aspects emerged from the groups' recommendations:

- The need for gathering and disseminating evidence so as to strengthen health services (this was argued especially in the context of mapping migration as well as the performance of diagnostic and treatment centers, and of establishing what works and doesn't).
- The need for information, as well as education and sensitization, especially in the context of addressing issues of marginalized population groups – not just sexual minorities but also marginalized population groups such as women, migrants, many of whom are from the scheduled caste and scheduled tribe communities, workers in the non-formal sector and so on.
- Special focus is needed on marginalized and more vulnerable population groups within every program.

Priority Recommendations

The chair, Dr Ruben F. del Prado, repeatedly stressed that the presentations dealt more with generics and listing of problems than with recommendations. He exhorted participants: "This is a Consultation … Let us have recommendations about innovations and measures that work better and faster and achieve more. What is important in prevention? What worked? Identify those. We will have to take two things that are important and crucial from each group. Find out who has done something spectacular or who has failed so that we don't repeat those failures."

The chair emphasized that the danger in listing several issues without prioritizing is that different donors could then be pulling in different directions.

The chair also emphasized that it is important that government policy should be clearly in place to ensure that donor money is used for enunciated country policy rather than be directed to contradictory programs.

He suggested that further discussion should focus on the questions:

- Is the donor agenda real or is it perceived?
- Where does it go wrong?
- Where is the disconnection between reality and perception?

Some specific areas were highlighted during the discussion at the plenary:

- The need for joint donor missions.
- Matching the agendas of multilateral agencies with country policy.
- GTT recommendation for harmonization – we have to behave, donors admit in their document.
- The need to provide funds directly to community-based organizations; currently funds trickle down to them; small CBOs and NGOs also need training on how to deal with donors and government.
- The European Commission (EC) needs to take the leadership role to balance the US-led bias (under the Bush administration) against condom distribution, distribution of free needles and so on.

Recommendations that were agreed upon included:

- The need to fund evidence-based operations research to validate what works.
- Share learning experiences across countries.
- Information dissemination to fight stigma.

The plenary concluded that, instead of trying to answer a number of questions, future group sessions should focus on one or two issues.

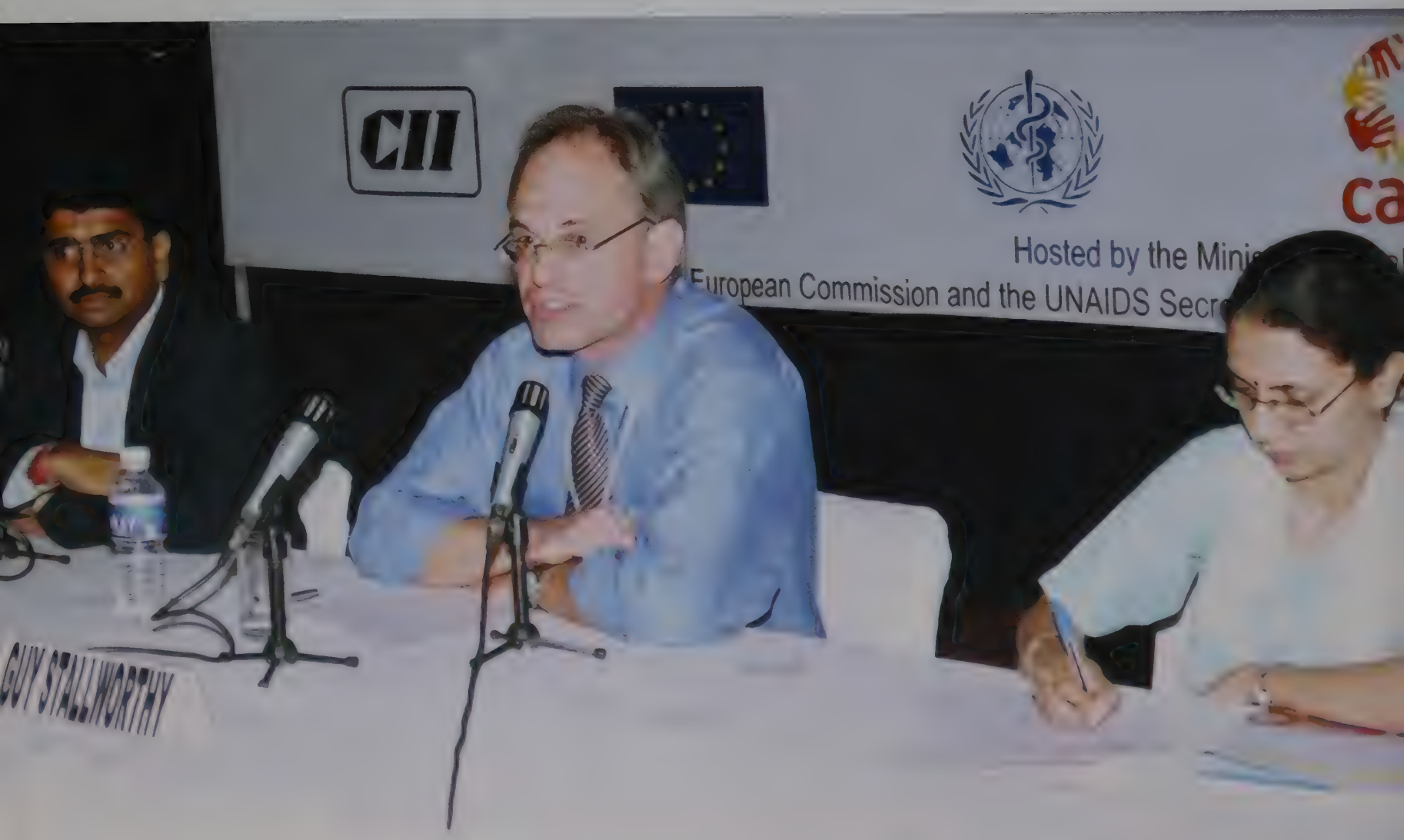
Social Marketing

The day ended with a discussion on Social Marketing hosted by the German Technical Cooperation (GTZ) at which presentations on 'Expanding Access through Social Marketing' were made by representatives of the Hindustan Latex Family Planning Promotion Trust and Population Services International.

The presentation on 'Expanding Access through Social Marketing' was made by Mr Amit Jain of Hindustan Latex Family Planning Promotion Trust, one of the largest social marketing organizations in India. Mr Jain gave an overview of Tarang Network in the four Indian states, and cited the use of training, building strong supply chains in rural areas, focus on behavior change communication and use of innovative methods as success factors.

'Engaging Market forces in the Control of HIV, TB and malaria' was the title of the presentation made by Mr Guy Stallworthy, Country Director, PSI Myanmar. Mr Stallworthy highlighted the activities of the Sun Network of PSI that have helped to expand the condom market in the country, as well as increased the case notification of TB.

In the discussion that followed, members of the audience raised pertinent questions related to the sustainability of social marketing, high cost of the female condom, etc.

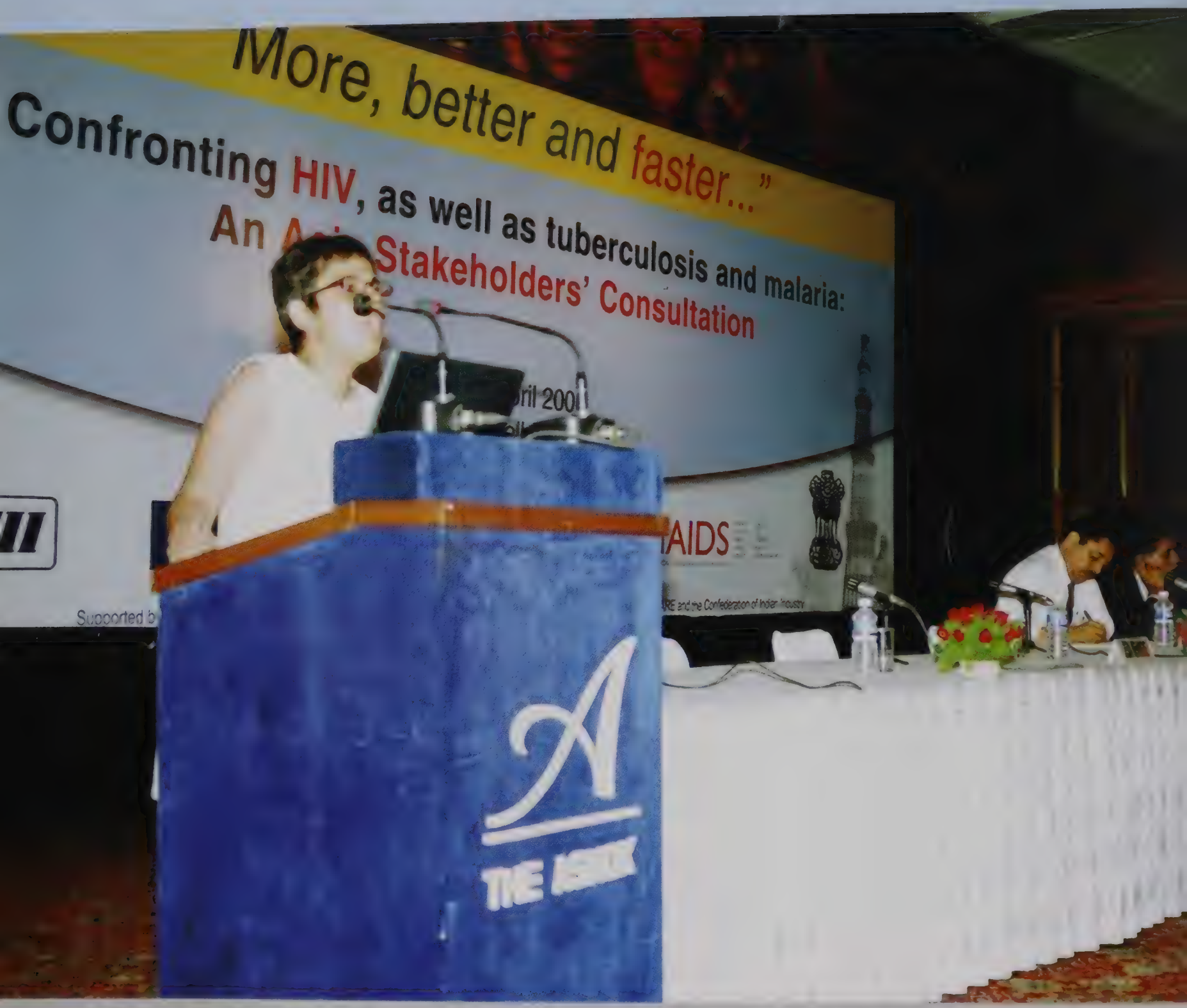


Mr Guy Stallworthy, PSI, Myanmar, Mr Amit Jain, Hindustan Latex Family Planning Promotion Trust (HLFPPT) and Ms Ramneek Ahuja of Confederation of Indian Industry (CII) on the dias during the plenary on Social Marketing

April 6

PLENARY 4

Focus on Development in the Era of Globalization



Ms Leena Menghaney, Access Campaign Manager, Medecins Sans Frontieres, Holland making her presentation as Dr Jai P Narain, Director, Department of Communicable Diseases, WHO SEARO presides over the session

Focus on Development in the Era of Globalization

Chaired by the World Health Organization Director of Communicable Diseases for Southeast Asia, Dr Jai Narain, the presentations at the Plenary – by Medecins Sans Frontieres (Doctors without Borders) Access Campaign Manager Ms Leena Menghaney, YRG Care Managing Director Dr Suniti Solomon and Reliance Industries Head of Medical Services Dr S Shanbhag – focused on access to essential drugs at affordable prices in Asia, and on specific initiatives (as typified by the Reliance and YRG experiences) in HIV and TB control in the private and non-profit sectors.

International aid agency MSF, which provides emergency medical aid and treatment to people in distress, has set up interventions for infections such as HIV, malaria and kala azar, among others, treating more than 60,000 people living with HIV in 29 countries, including India, China, Thailand, Indonesia and Myanmar. Most patients in their treatment programs receive affordable generic medicines manufactured in India that allow MSF to treat the largest possible number of people. Ms Mehangney emphasized: "Access to affordable medicines is key in making life-extending treatment available to more people who need it."

Till recently, some countries – among these India, Indonesia and Thailand – had protected themselves against the product patent regime and the consequent expensive drugs by strengthening public sector manufacturing and, as in the case of India, opting for process patents. "The 'no product patent regime' in India led to the development of a robust generic industry that does not only meet its domestic needs, but also supplies other developing countries," said Ms Mehangney. She shared that most treatment programs in developing countries procure affordable antiretroviral drugs from India. Other measures like price control of essential drugs have also helped.

Governments in the region, it was stated, could do more – including compulsory licensing of essential drugs – without violating the Trade-Related Aspects of Intellectual Property Rights (TRIPs) Agreement, to which India and all other World Trade Organization (WTO) members are signatories.

With global adherence to WTO-TRIPs norms, most countries in Asia with pharmaceutical manufacturing capacity, including India and China, have introduced a product patent regime in recent years. This, it was argued, would:

- Endanger global access to affordable medicines including in Asian countries;
- Allow only the patent holder to manufacture and market drugs, preventing generic manufacture in developing countries; and
- Affect manufacture of generic and affordable drugs, if patents are granted for essential drugs, including antiretroviral drugs.

What Happens if Patents are Granted in India?

Indian companies are in the process of developing second-line and new first-line antiretroviral drugs (TDF, Kaletra, Atanazavir/r). With generic manufacture in India, the prices of new antiretroviral drugs are expected to become affordable.

However, if patents are granted on any one of these drugs, generic manufacture in India will be affected, impacting both price and availability.

In China patents on Efavirenz and lamivudine (3TC) have forced the government to procure these from Merck and Glaxo despite the fact that cheaper generic substitutes are available.

Impact: Imbalance between Needs and the Availability of Medicines

- Originator companies fail to register and market their products in Asian countries.
- People living with HIV in developing countries can't get new and/or improved drugs that can make a critical difference, unless these drugs can be manufactured generically. Recent examples of pharmaceutical companies not introducing HIV drugs in Asia include that of Gilead failing to register and marketTDF and Abott failing to do the same with Kaletra thermostable.

What Governments can do

- Prevent trivial patenting of essential drugs: Not all patent applications are valid. Many of the applications do not claim real 'inventions' but are for a new use of an old drug, or simply for derivatives of old drugs or combinations of old drugs. The Indian Patent Act provides several grounds for rejecting a patent, for instance if the pharmaceutical substance claimed is only a new form of a known substance.
- Prepare for a compulsory licensing mechanism.

– From the presentation by Ms Leena Menghaney, MSF

April 6: Breakout Group Discussions

Group 1: Early Diagnosis

The session started with presentations on 'Improving Laboratory Facilities for Early Diagnosis', 'Scaling up Testing' and 'Quality Assured Diagnosis in TB'.

Taking off from an overview of the diagnostic testing capacities in the Asian countries, with specific details of testing for TB in India and for malaria in Cambodia, the presentations focused on whether laboratory capacity is a critical component of healthcare programs, and whether a policy is required to build adequate capacity. It was argued that a policy is, in fact, required to ensure that there are adequate laboratory facilities in terms of both quality and coverage, and that these are optimally utilized. The presentations also argued for adequate protection and proper working conditions for laboratory workers, who should be considered a high-risk population group. It was concluded that diagnostic facilities require attention to the 10 'M's: Man (human resource and training); Machinery (equipment); Material (reagents and so on); Methodology (protocols); Management; Motivation; Monitoring and evaluation; Maximum containment (BSL3); Matrix (network) and Money (resource allocation).

In the open discussion that followed, participants emphasized that the absence of a policy for laboratories in the Asian region is a matter of great concern, since it adversely affects the

diagnostic process in terms of timeliness (early diagnosis) and quality issues. They also suggested that policy should address the issue of bringing down existing barriers between medical doctors and laboratories, and repeatedly emphasized the need to stipulate quality assurance – including quality control standards and measures, as well as stipulations for training of laboratory personnel. WHO and other professional bodies should be involved in laying down such quality assurance procedures. In addition, they suggested that every country should establish an independent accreditation agency and requires compulsory accreditation for all laboratories, both public and private. Participants also pointed out that HIV tests in India have guidelines for 3-test results, but private laboratories do not follow this requirement, and suggested that quality control norms would address such problems.

WHO and other professional bodies should be involved in laying down quality assurance procedures. Every country should establish an independent accreditation agency and require compulsory accreditation for all laboratories, both public and private. Participants also pointed out that HIV tests in India have guidelines for 3-test results, but private laboratories do not follow this requirement and suggested that quality control norms would address such problems.

Group 1: Early Diagnosis
Recommendations

- A policy for laboratories should be comprehensive, not just for one disease, but for all, including HIV, TB and malaria and others. This should also cover issues of quality assurance.
- The policy should be backed by legislation and pertain to both the public and private healthcare services.
- An accreditation system is needed for laboratories. The accreditation should involve a periodic evaluation process. Thailand and Sri Lanka have policies for accreditation of laboratories.
- Standardization of methodologies is also required.
- Diagnostic laboratory services are even less available in rural areas than clinical services; government policy emphasizes clinical services and ignores the need for diagnostic services in rural areas.
- Facilities for early diagnosis should be accessible in villages. Rapid diagnostic tests should be introduced on a large-scale basis in rural areas. If necessary, mobile testing facilities could be made available, as in the remote villages of Thailand. Rapid testing allows for diagnosis within 30 minutes followed by administration of drugs. However, service providers should be aware of the dangers inherent in rapid testing and ensure quality assurance.
- Reagents for rapid diagnostic tests should be suitable for remote areas; manufacturers should be encouraged to produce reagents with longer shelf life.
- The community and professionals should be involved in the delivery of laboratory services. This will help in ensuring quality.
- Village healthcare workers should be trained to detect suspected malaria and TB cases, and in facilitating access to diagnostic services.
- Service providers of national programs should be sensitized to the importance of laboratory diagnostics.
- Diagnostic facilities should be made available to the community by the government as well as by the community itself.
- Quality issues should include measures to ensure the safety of laboratory workers.

Economic Cost of HIV, TB & Malaria

- TB: US$ 12 billion/year
- Malaria:
  - 1.9% less per capita GDP growth in countries with high transmission of malaria
- HIV:
  - 0.3% lower GNP in Sub-Saharan Africa; 5.3% lower GDP in Trinidad and Tobago
  - US$ 9 billion lost in Thailand and 11 billion in India (by 2000), mostly as indirect costs
- Adversely affect progress towards MDG

– From the presentation of Dr Jai Narain, World Health Organization Director of Communicable Diseases for Southeast Asia, at the Inaugural Plenary

Participants also suggested that governments in the region should enact policy to encourage more research in diagnostic technology and manufacturing of diagnostic kits. Research organizations, private sector and international agencies should collaborate in the process, which should also be aimed at bringing down the cost of good equipment and diagnostic processes.

Group 2: Economics of Treatment

The discussion took off from presentations on 'Patents and Pricing', 'Industrial Issues and Role of Asian Companies' and 'Workplace Service Referral'. While the latter two presentations focused on the evidence of workplace experiences and on the effectiveness of 'smart cards' that help track treatment adherence, the first presentation concentrated on the political-economics of patents. The 'smart cards' are currently being tested as a pilot project in India.

Prefacing the arguments with the comment that patents constitute a public policy tool to promote and reward innovation, to disclose the invention, and make it available to society, the presentation pointed out that people's access to (essential) drugs depends on rational selection and use of drugs under the patent regime, adequate and sustainable financing, affordable prices and reliable supply and healthcare systems. While public spending accounts for a large part (50 percent to 90 percent) of total expenditure on pharmaceutical products in developed countries, in under-developed or developing countries, it accounts for a very small proportion (between 5 percent and 50 percent). It showed how patents have pushed up prices of antiretroviral drugs. Examples of countries successfully using clauses within the existing patent laws to the benefit of people include Cambodia, which, categorized as a 'least developed country' under the WTO, has postponed applying its existing patent regime to the pharmaceutical sector, an example that other 'least developed' countries could follow. Generic production of antiretroviral drugs is allowed in countries like Thailand, Brazil and India; however, some pharmaceutical corporations have challenged this.

The lessons drawn from these experiences are that it is important to make 'smart' patent laws. It is important also to make use of the options that are already there, given that the law is not perfect, identify and use the 'gaps' in the patent laws. Most important, it is necessary to consider how to create 'gaps' where these do not exist. It was argued, finally, that the way forward is probably country-specific, and will require strategic action.

In the discussion that followed, it was emphasized that, in the given WTO-TRIPs regime, governments could nevertheless reduce the cost of treatment not only through developing smart laws and making smart use of existing laws, but also through more efficient use of available resources (as for example, proper use of GFATM grants; many countries in the region have failed to use these grants fully).

Participants pointed out that financial resources for healthcare systems should be augmented through:

- Government funding for a comprehensive primary healthcare system;
- Instituting a government-led social insurance system in which employers contribute and services to the indigent are subsidized by government (as is happening in the Philippines);
- Instituting income-differentiated user fees for healthcare services, with cross-subsidization;
- Instituting care by employers, showing evidence that this is a savings in the long run in terms of benefits as also in terms of consolidating savings by keeping patients healthy and able to work (as ILO studies have proved).

Further, participants focused on the need to identify viable safety nets to provide treatment support in health contingency. Related to this, there was also discussion on insurance coverage, the role of the corporate sector in insurance and the critical role of the government (specifically the health ministry) therein.

Group 2: Economics of Treatment
Recommendations

Augment Financial Resources for Healthcare System by Way of -

- Government funding for comprehensive primary healthcare system
- Government-led social insurance system in which employers contribute and services to the indigent are subsidized by government (example of Philippines)
- Income-differentiated user fees, with cross-subsidization (example: YRG Care)
- Care by employers, showing evidence that this is a savings in the long run in terms of benefits (ILO studies)
- Consolidating savings by keeping patients healthy and fit to work

Reduce the Cost of Treatment by -

- Developing smart laws and making smart use of existing laws
- More efficient use of available resources (example: GFATM grants for countries in the region)
- Re-designing treatment systems for comprehensive care (example, diagnostics, treatment of OI,TB and ART in one clinic)
- Invest in treatment literacy for users
- Instituting and investing in systems for collection, analysis and availability of data for treatment management

Role of Workplace and TUs

- Make workplace the intermediary agency between patients and service providers
- Trade Unions can function as advocates and facilitators of treatment

Emphasize on Advocacy with –

- Parliamentarians, to enact smart laws
- Health Ministry, for better utilization of resources and for smart laws
- Media, to act as a watchdog and generate supportive environment

Action Points for Improving Access to Treatment –

- Advocacy has to be led by civil society, especially patient and support groups
- Development partners to help build capacity in government and civil society
- Private sector, in healthcare, insurance and outside, to play a facilitative role
- Government to lead in universalizing access through financing and provisioning mechanisms, better regulation of healthcare and related sectors, using international negotiations to the country's advantage

It was pointed out that the workplace is an effective intermediary agency between patients and service providers, and that trade unions could function as effective advocates and facilitators of treatment. Participants also asked for a demonstration of the 'smart cards'.

Group 3: Procurement, Supply and Management of Pharmaceuticals and Diagnostics

Presentations on 'Regulatory Capacity and Pre-qualification' and on 'Local Procurement by and for Civil Society', which preceded the open discussion, argued for regulation.

It was contended that distribution of sub-standard drugs, and the lack either of strong legislation or of regulatory mechanisms was the main obstacle to pre-qualification. Equally, lack of regulation is responsible for lack of transparency in procurement procedures. It was argued that transparency could be achieved by making pre-qualification criteria known, and suggested that quality aspects should be built into procurement systems.

Pre-qualification is required as the regulatory capacity is not the same across countries. WHO, which has been in collaboration with other international agencies on issues of pre-qualification and regulatory capacity, has a set of guidelines and parameters (covering technical as well as ethical issues) for manufacturers. Many products in the market today do not meet these criteria. Many companies do not even have bio-equivalence standards.

It was argued that pre-qualification eases access to treatment.

Further, it was asserted that an efficient supply chain, with economically viable distribution systems, is essential. It is equally important to have a clear policy for the availability of essential drugs in public healthcare facilities, including transparent institutional systems such as an open tender and bidding system for procurement and pre-qualification criteria. Procurement could initially be limited to essential drugs, and should be by generic – not brand – names. The drug requirements of all state healthcare facilities should be pooled. Drugs be sourced only from manufacturers, not traders.

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In the open discussion that followed, the key recommendation was that while procurement of drugs must be centralized, supply should be decentralized. Drawing on successful experiences in Thailand and pilot projects in India, it was contended that information technology could be used to improve the tracking of both manufacturers and migrating patients (as with 'smart cards').

Participants emphasized that better enforcement of laws, technical training for enforcement agencies and greater commitment from political leaders are necessary to tackle the problem of counterfeit drugs, which is a major problem in Asian countries.

Group 3: Procurement, Supply and Management of Pharmaceuticals and Diagnostics
Recommendations

To do Better

- Enforce laws and regulations for procurement, and to deal with counterfeit medicines
- Build capacity for regulatory and quality assessment
- Centralize procurement (advantage of volume/pricing/negotiation)

but

- Decentralize operations of supply chain – involve CBO (different roles at different levels)
- Use IT, for traceability of manufacturers and patients (Thailand, India pilots)

To do More, Better and Faster

- Inform regulatory authorities and communities about the problem and risks of counterfeit medicines
- Countries without manufacturing capacity investigate regional mechanisms to check counterfeit medicine

The group recommended that donors should support governments in improving quality control and regulatory mechanisms, especially necessary to check the spread of sub-standard drugs. Often, the quality of drugs deteriorates because of poor distribution networks, and patients receive these close to or beyond the expiry date. It was suggested that cooperation between countries in the region would help tackle the problem of sub-standard drugs.

Group 4: Partnerships for Health

Presentations on 'South-South Collaboration on Expanded AIDS Vaccine Research', the 'Stop TB Partnership' and 'Accessing European Commission Funding – A Way for Partnership with Civil Society Actors' put forward different aspects of partnership, also detailing processes of accessing EC support and the working of the WHO-sponsored combat TB Program.

All developing countries face similar challenges in the healthcare sector – high burden of disease and poverty, inadequate healthcare delivery systems, poor access to services and treatment, inadequate resource allocation and relatively low prioritization of health research efforts. At the same time, most have high levels of untapped skills, low administrative costs for conducting trials, few commercial competing interests, and good community infrastructure and NGOs. It was argued that experiences across countries with similar situations could be horizontally shared, the learning thereby moving from the local to the national and on to the global level. Synergies in program implementation as well as in research and development, equitable technology transfers, networking and dialogue can make available safe, effective preventive vaccines for all. Civil society cooperation and a bottom-up approach for HIV prevention were underlined, as was the potential and need for joint advocacy across the region.

The subsequent open discussion focused on various aspects of South-South collaboration, going beyond the area of HIV to suggest information sharing on all health and healthcare-related issues through virtual and real interactions, training, and integration and convergence of health services through committed public-private cooperation. The need for guidelines to prevent irrational use of drugs was agreed upon. Community involvement and inter-sector partnerships on issues like food security, psycho-social support, income-generation programs and welfare networks were proposed. Alliances inclusive of different stakeholders were proposed.

In the context of proposals to expand partnerships to eradicate malaria, TB and HIV, a Cambodian initiative integrating programs for HIV with sexual and reproductive health programs were discussed. Some participants opposed such integration on grounds that marginalized groups (such as intravenous drug users, sex workers and homosexual men) require specific attention that is not closely linked to reproduction. Moreover, such population groups rarely access reproductive healthcare settings. However, it was agreed that those marginalized groups (intravenous drug users, sex workers and homosexual men) are not being neglected in Cambodia. There are many NGOs promoting education, condom use, behavior change communication, and access to healthcare services in partnership with the government.

Other participants brought up the need to include hepatitis in the integrated approach to healthcare services.

The recommendations were:

- Information sharing between developing countries;
- Joint training programs between developing countries;
- Public-private partnerships with clear role demarcations;
- Joint strategies for common programs like DOTS expansion; and
- Joint strategies for rational drugs use.

Group 4: Partnerships for Health
Recommendations

- Integration and convergence
  - TB and Malaria esp. remote places without benefit of diagnostic services.
  - Expansion of services (H-T-M) integrated approach at the grassroots.
  - VCCT/TB integrated clinics.
  - Need more TB/HIV/hepatitis diagnostics in VCCT centers. Referrals are an issue.
  - Need harmonization.
  - Integration of TB into HIV prevention programs: ie: CCM.
  - CCM internal advocacy
  - Selective convergence with regard to resource allocation
- Partnership
  - North-South-South partnership
  - HIV and TB and Malaria (where it is most appropriate)
  - Public and private (multi sectoral) sectors
- Clear roles and functions of partnerships
- Clear plans, frameworks, direction and system
- Operational guidelines and policies
- Involvement of community workers in community mobilization
- Sharing of expertise, experience (virtual centers)

Participants emphasized the importance of partnerships within and across countries, as well as the need to identify and establish rational processes to access donor funding.

Group 5: Treatment Adherence

The session began with presentations on how 'Mobilizing the Red Cross Network to Improve the Quality of Life of People Living with HIV through Community Action' (focusing on experiences in Cambodia), and 'Community Involvement in DOTS Provision' helped in promoting treatment adherence.

The experience of a DOTS program in Bangladesh focused on the need for educating and empowering the community on health issues, and the pivotal role of female community health volunteers in the program, particularly in ensuring adherence to treatment, in this case DOT services for TB.

Community health volunteers encouraged patients to take the required drugs regularly, visiting patients at their homes for follow-up, especially so when they failed to turn up at the clinic. This helped save on the patients' travel cost and time, enabled early detection of side effects and ensured higher compliance and decreased dropout rates. It also ensured regular follow-up for successive sputum tests.

It also helped increase awareness of TB at the community level, through social mobilization increased accessibility to DOTS services and improved monitoring. The program involved patients voluntarily transacting a financial bond for the completion of treatment and an incentive scheme for community health volunteers.

The open discussions began with the group focusing on the need for patients to realize the importance of treatment adherence, and listed stigma and discrimination by communities, lack of education and awareness and lack of accessible services as the reasons for non-adherence.

With respect to increased involvement of community with the government healthcare system, it has generally been found that government agencies and officers are usually hesitant to involve community service providers. Procurement problems and inadequacy of support at hospitals are also major obstacles.

Basic education on health issues for healthcare providers as well as for the community, and specifically for patients, plays a significant role in achieving success. Sensitivity to gender perspectives is especially important to ensure adherence to treatment, more so in the case of HIV infection, but also for all other infections. Participants also discussed how social status, inequity and other patriarchal dimensions impact adherence, and suggested that counseling of women requires special attention.

Poor economic conditions, superstitions, stigma, inadequate number of treatment centers, unaffordable treatment and other socio-economic issues such as lack of transportation, lack of time due to long hours of work and distance from the treatment center also impact adherence, participants said, as also the lack of support and effective – or even adequate – counseling.

Regarding incentives to volunteers, there was disagreement and some group members felt that it had its drawbacks. It might be a better idea, they said, to identify volunteers who did not have to be provided with incentives. With respect to volunteers, one group member also said that the overlapping areas of activity led to friction between volunteers and government staff.

However, participants recommended that the approach taken by TB programs in Pakistan – seen as a 'holistic approach' – should be emulated; this approach linked patients to social rehabilitation services, and provided incentives in the form of micro-finance, food packages and so on. It was agreed that self-help groups play a significant role as support structures and resources for adherence, and require training, especially in counseling, in the initial stages. Participants also argued that lack of funds aggravated the likelihood of non-adherence; however, they agreed that dependence on donors is not a solution.

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Group 5: Treatment Adherence
Recommendations

- Proper education of patient, family and community is needed. It was recommended that health education be included in school curriculum and information disseminated through peer learning as well. This would also be a step in moving from a purely clinical and curative approach to a preventive one. It was emphasized that treatment education for the community and for people with HIV is extremely important.
- Government leadership and ownership is critical; this would involve long-term planning and sustainability. Special focus on taking the services to the poor is necessary; this is a function that only the government can fulfil. It was agreed that lack of funds is a major obstacle.
- Procurement problems at healthcare centers at village, block and district levels need to be addressed. Adequacy of support at hospitals, which remains a major cause for inadequate treatment, also needs to be stepped up.
- There is need for WHO protocols to be applied with specific regard to country situations. These and government protocols need to be shared and disseminated among healthcare workers.
- With respect to adherence to treatment of TB, special recommendations were made, including –
  - Community involvement during treatment, especially of youth;
  - Using community volunteers as DOTS providers;
  - Domiciliary method;
  - Involvement of community-based groups, such as the ASHA volunteer under the National Rural Health Mission; and
  - Implementation of new monitoring systems.
- Increased involvement of community with the government healthcare system can be initiated by demonstrating the use of community volunteers in villages. Support organizations of people with HIV also play an effective role in adherence. Increased role of such groups is required in HIV counseling and in the continuum of care, suggested participants.
- Increased involvement of private medical practitioners in referral, sputum examination and treatment was agreed upon and recommended as a factor leading to a 90 percent increase in patient adherence to treatment.
- Information related to the side effects of the medicines should be provided on the package itself. In addition, user-friendly messages promoting adherence could be conveyed creatively – for example, different sized boxes for different days of the week could be used in order to help the patient maintain medicine intake and thereby improve adherence.
- It was emphatically stated that packaging should not be changed every now and then as it causes confusion among patients.

In addition to specifically targeting patients for adherence, it was suggested that there should be –

- Proper assessment of the concomitant diseases or infections.
- Proper selection of drugs; proper combinations; decreased burden of pills.
- Prioritizing what treatment should be started first and what next to avoid drug-drug interaction. Treatment should begin with counseling.
- Counseling for adherence, from time to time.
- Counseling on giving up alcohol, tobacco and other pleasure-drugs.
- Follow-up tests and investigations.

Participants also discussed issues of political leadership, NGO activity, community education, quality of diagnosis, training of staff, reporting and sustained financing as issues that impacted treatment adherence.

It was unanimously agreed that prevention, care and support need to receive equal attention and that community and family support are essential, as is the involvement of NGOs and civil society.

The group agreed that time-bound, target-oriented programs for low-income patients may not be an effective solution. The positive deviance model was seen as effective for building community support towards adherence issues. Of course, adequate time would be required for the same.

It was recommended that unqualified medical practitioners could be engaged as volunteers with or without incentives. Careful selection of volunteers and upgrading their capacities and qualifications were seen as essential to the success of the programs. An integrated training and capacity building of the volunteers targeting TB, HIV and malaria would prove to be cost-effective.

Treatment monitoring and evaluation was discussed, and it was recommended that strategies be developed and implemented for monitoring and evaluating treatment adherence.

April 6

PLENARY 5

Round-up of Group Work and Summarizing the Challenges in Treatment

A view of the participants at the group session. Dr IS Gilada, People's Health Organization and Mr Aminul Bhuiyan, Additional Secretary, Ministry of Health & Family Welfare, Government of Bangladesh in the forefront

Round-up of Group Work and Summarizing the Challenges in Treatment

Chaired by Dr Steve Hollingworth, the plenary had presentations on the recommendations of the breakout group discussions. This was followed by a talk by Dr Suniti Solomon of YRG Care on 'Challenges in Care and Support for People with HIV' and by Bobby Ramakant of AIDS Care Watch on 'Tuberculosis Treatment and Care'.

The importance of affordability for patients was emphasized, as also the importance of financial sustainability of support organizations and the need for NGOs and other organizations to work together in order to respond effectively to public healthcare challenges. A rights-based approach to TB and malaria care was advocated with involvement of the patients at every stage, including in planning. It was also highlighted that there is a need for a clear criteria for recruitment of front-line healthcare workers.

The problems arising out of a lack of adherence and the consequent need for expensive second-line treatment were highlighted; this problem especially impacts the poor.

Group 6: Continuum of Care

The group began its proceedings with presentations on 'Budgeting for Community and Home-based Care' (based on the experiences of the Committed Communities Development Trust, India), and on the 'Role of Communities in Care and Support' (based on the experiences of the Spirita Foundation, Indonesia), both focusing on people infected with and affected by HIV.

It was argued that home-based care is sustainable and cost effective; also, it was emphasized that it is sustainable because it is cost effective. In the case of people with HIV, home-based care is especially important because it allows for sensitive care, keeping cultural and religious concerns and value systems in mind, addresses community and emotional needs, provides comprehensive care in a familiar environment – all components of effective counseling. It also allows people with infections to attend to their non-health problems and concerns, such as family, legal and other matters.

Community-based care serves the same purpose, with the added targeted benefit of enhanced care and support and increased access to treatment.

It was pointed out that with home-based care the need for hospitalization often decreased; community-based care also costs less as community support allows for access to the right care at the right time, bringing down healthcare costs.

For government this is also beneficial because all basic services – counseling, nutrition and healthcare support – are provided at the home and community levels.

Participants pointed out, however, that the (experiences described in the) presentations did not take into account issues of access and of moving from care to prevention for family and other community members.

They also pointed out that it was not clear who would continue to pay the NGOs that operate the care structures; it was unclear whether the government would do so. It was suggested that NGOs involved in such initiatives should carefully detail the cost-components of their operations for further evaluation as to viability.

Participants also emphasized that it is important, in both home- and community-based care structures, that NGOs should move from a merely sympathetic approach to building self-help structures. In this context, it was suggested that self-help groups of HIV-infected people could meet some of the needs of infected people. An example cited was West Bengal in India where HIV-positive people's networks that have undertaken to run home- and community-based care are attempting to set up micro-credit systems.

It was suggested that there should be a link between relief and development funding, and NGOs should look to identify internal resources, where 'internal' means 'community' resources such as local churches, market associations and so on. It was pointed out that emergency funds can be provided for a limited period of time, and suggested that stakeholder mapping to decide resource mobilization and allocation would be useful. Further, it was suggested that HIV (as also other infections) has a multi-sector impact and, therefore, involves different government departments, all of which may be tapped for fund allocations.

Participants also called for further discussion on the special needs of continuum of care for migrant workers and for linking workplace intervention programs to ensure continuum of care structures.

They also pointed out that wherever there has been a decrease in the incidence of HIV infection – as in Brazil, Uganda and Thailand – there has been strong political commitment to the program. Apart from committed political leadership, participants emphasized the need for developing critical capacity in delivery of management capacities.

Dr LS Chauhan, Deputy Director General (TB), Central TB Division, Ministry of Health and Family Welfare, Government of India, and other participants during the plenary session

Group 6: Continuum of Care
Recommendations

- Building an empowering mechanism that allows for developing capacities in home and community-based care. This would include specific budget allocations from government for such care.
- Strengthening existing support systems, especially the technical expertise and capacity of intermediaries.
- Implementing the recommendations of GIPA regarding access and partnerships with government.
- Ensuring sustained funding for NGOs operating home- and community-based care.
- That people with HIV should be the main movers, especially in counseling.
- Building regional networks for support and learning; existing networks can help strengthen new organizations.
- Donors who work with specific diseases need to get together with specific NGOs (e.g. TB and malaria prevention and care networks).
- Ensuring the continuum of care for migrant workers, truckers and other mobile populations; the 'smart card' could be one means to do so.
- Instituting single-window services for HIV-TB-Malaria prevention and treatment services; this would also strengthen continuum of care.
- Strengthening PHCs (through training, personnel and finance) by having peer educators for home and community-based care.
- Ensuring equal budget support for prevention and care.
- Instituting culturally appropriate guidelines; also taking into account the special needs of children, who need to remain in school and also are more vulnerable.
- Involving people who matter in consultations, regarding decision-making and budget allocations and so on.
- Learning from the successful interventions in Cambodia, Indonesia, Thailand and Tamil Nadu in India, which had meaningful involvement of infected and affected people as a core element.
- Furthering regional support and learning by using existing networks to strengthen new organizations.
- CSOs need to identify specific elements of the continuum of care and support for which they can take responsibility and cost these in detailed break-up.
- Strengthening existing support systems through training in the range of required skills, from management and negotiation skills to advocacy, technical and other competencies.
- That the continuum of care should be ensured for mobile population groups (such as migrant workers, truckers and others) through government, professional and non-government networks, and measures such as the 'smart card' for healthcare services developed by the India Development Foundation.
- Harm reduction programs for intravenous drug users must be included in all programs for continuum of care and support, as injecting drugs is a major driver of HIV and Hepatitis.

On the basis of the presentations and the experiences of initiatives in various countries – including Cambodia, Myanmar, the Philippines, Brazil, Uganda, Thailand and India – described during the discussions, the group acknowledged that effective continuum of care is necessary to meet the challenges of caring for people with HIV, TB and/or malaria and other infections (mentioning hepatitis in particular), emphasizing also that this must be extended to continuum of support.

Group 7: Equity in Access to Healthcare Services

Presentations on 'Hard-to-Reach Populations' and 'Social Exclusion' preceded the discussions. In the information and arguments offered, the focus was on the obstacles faced by vulnerable groups – discrimination and stigma, cost of treatment, gender-based violence and the USAID policy – in accessing services.

It was emphasized that the need of the hour is to have effective rather than expensive communication, and this could be achieved only through the involvement of the target population in the development of communication material and program design. This was illustrated through the experiences of networks of sex workers and of men who have sex with men.

"Sewing machines are not the answer to the economic problems of sex workers," it was stated. The example of Sonagachi cooperative project was cited where sex workers formed a cooperative that provides loans to and supports income-generation activities of its members.

The lack of recognition of sub-groups from within the marginalized groups requires special attention – better identification, assessment and accessibility – and mainstreaming through working closely with CBOs and the government support structure. It was highlighted that while efforts are on to integrate the two largest health-related programs – reproductive and child healthcare and HIV care – these target totally different client populations. The population groups at high risk to HIV infection are largely marginalized in the reproductive care structure.

Describing two different approaches to effective program implementation, especially with reference to access to services, it was suggested that mainstreaming of the CBOs (of hard-to-reach or marginalized groups) could be achieved with the help of training, and through the use of peer educators from the local community who would be trained to provide primary care to infected individuals and then forward them to the nearest healthcare facility. Such processes would tend to reduce stigma and discrimination (as proved by the experience of organizations of marginalized groups; in one example, homosexual men have been trained and placed in various government out-patient departments to help people with their enquiries). As people get used to interacting with such marginalized people and seeing them as helpful and responsible people, the discrimination based on sexual preferences would tend to reduce and subsequent acceptance and mainstreaming would be realized.

In the subsequent discussion, the group focused mainly on the issue of stigma and discrimination as a major hindrance to access services. It was agreed that discrimination cannot be tackled at any one level of society; instead it needed a multi-pronged approach. The group suggested tackling the problem at different social levels – from the family to the funding agencies.

It was proposed that the family should be motivated to provide primary care. Treating the disease at home by household members would provide the individual with a patient status like any other ailment and would help in removing stigma and discrimination. Sharing experiences within the extended family and circle of friends would also help in removing stigma in the community. This point was elaborated upon through the example of Indonesia and its DOTS program, where the system of household members providing primary care could have developed for different reasons, but it had an indirect effect in reducing stigma and discrimination.

The group recognized the fact that it is not enough to just tackle the problem of stigma and discrimination with reference to access to healthcare services; stigma has to be removed from the community in a holistic way as, in a number of cases, the infected individual or the affected family is restricted from access to even basic services like water and so on.

It was recommended that there is a need for general awareness building at the level of family and community about infectious diseases, sexual identity, behavior and preferences, which can be done with the support of CBOs, upgrading school curricula and training of teachers. This can further be propagated through the development of the right kind of communication material. The group also recommended operational research for the understanding of social attitudes towards sexual preferences, especially in communities that do not treat differential sexual preferences as taboo. The understanding of these nuances would lend support to the formulation of targeted intervention

Group 7: Equity in Access to Healthcare Services
Recommendations

For Family and Community:

- Involvement of family-members in care and support for patients.
- Family awareness on sexual practices (education at school, community workers, health workers) – operation research required.
- Research program and curriculum development on specific diseases highlighting reduction of stigma and eliminating myths (proper context/ appropriate language).
- Influential people in community should speak out about HIV/TB/Malaria and be actively involved in prevention, care and treatment.
- TV/Radio/Media to provide free/pro-bono support to health issues at least once a month.

For Program and Policy-making:

- Curriculum development in all healthcare personnel training to address stigma reduction.
- Ethical guidelines and tools addressing patient rights for professional societies (doctors, nurses, pharma etc).
- Laws discriminating or criminalizing vulnerable groups to be abolished.
- Laws in support of equity and vulnerable groups to be reinforced through inspections, community watch groups/ NGOs.
- Campaigns to not focus on marginalized/ vulnerable groups but reflect the overall population is at risk of TB, HIV, malaria.
- Politicians at all levels to show solidarity and commitment on regular basis (e.g. visits to patients, health centers).
- Forum of parliamentarians on HIV to raise specific points on health matters during regular parliamentarian meetings.

For Funding Agencies:

- Donors should fund programs based on needs and concrete evidence, and not based on moral/ideological opinions.
- Calls for proposals should include specific points on stigma and vulnerable groups.
- Funding tracking mechanisms to be put in place – spelling out the proportionate support given to stigma and vulnerable groups.
- Behavior change and stigma reduction projects to be funded through long-term commitments.

against stigma and discrimination. Tapping the mass media was seen as an effective mechanism for spreading awareness, but here again the group insisted on the requirement of effective and repeated communication using different tools.

Other recommendations for community-based initiatives included identifying common grounds or platforms for sharing successful cases of recovery, especially if the individual holds an influential role in the community, or social initiatives, clubs, etc., which would form a consortium of commonly-faced problems and shared experiences so that the discriminated population can come together and speak up for itself. Participants also argued that economic empowerment of infected individuals would be an important move towards the removal of stigma and discrimination both within the family and in the community.

The group recommended that professional societies should have ethical guidelines and tools addressing patient rights. Training curricula for healthcare personnel should address stigma reduction, and any healthcare service provider who refuses to attend to a patient should be reprimanded or fined. There should not be a separate targeted program for combating stigma and discrimination; instead it should be a prominent part of every program. This recommendation was taken forward to say that campaigns should not focus on marginalized and vulnerable groups alone, but reflect that the overall population is at risk of TB, HIV and malaria.

A description of Thailand's health sector reforms highlighted the various insurance schemes that have been provided for workers and their families. This has made the government an active stakeholder in corporate social responsibility programs, and is an important factor in the country's efficient implementation of health schemes.

The group suggested the need for laws in support of equity in behavior towards vulnerable groups, which should be reinforced through inspections, community watch groups and NGOs, while those discriminating or 'criminalizing' them should be abolished or not applied. There was recognition of the need for rehabilitation of prisoners after release and to advocate rehabilitation along with sensitization about sexual preferences, sexual identity and such issues.

Participants stated that political commitment towards the removal of stigma and discrimination is an important intervention. Politicians need to contribute towards the removal of stigma and discrimination by openly lending repeated and active support to the cause. Initiatives like the leadership expressed by the Prime Minister of China and His Royal Highness of Thailand as well as the Forum of Parliamentarians on HIV in India and the inclusion of ten minutes of deliberations on the topic of HIV/AIDS in every political and government office meeting at the state, district and block level in the state of Maharashtra were described as good examples of how political leaders can make a difference.

Finally, it was recommended that behavior-change and stigma reduction projects should be funded through long-term commitments. Donors should fund programs based on needs and concrete evidence, not on moral and ideological opinions, and the ownership of the program should be transferred to the community.

Group 8: Corporate Social Responsibility

With presentations on 'Rural Health Insurance and Social Safety' and on 'Caring Beyond the Worker' laying the grounds for the dialogue, the discussion veered into focusing on definition of 'corporate social responsibility'.

A description of Thailand's health sector reforms highlighted the various insurance schemes that have been provided for workers and their families. This has made the government an active stakeholder in corporate social responsibility programs, and is an important factor in the country's efficient implementation of health schemes.

In the business of providing rural health insurance, corporate organizations are concerned with customer attitude (where they generally see a doctor only when it is absolutely unavoidable), and the functioning of service providers (where quality is a major concern, and care is unilaterally decided by the doctor). The outcome, it was argued, is that cost of treatment is high, people suffer loss of income, incur high cost of travel and other indirect expenses. It was emphasized that indirect expenses related to health care are still too high, often causing indebtedness.

> The bottom quintile, the poorest 20% of the population, spends a larger part of its income on health care, at more than 12% than the top quintile, which spends approximately 3%.
>
> – From the presentation by Ms Kamalnaini Sharma, Deputy General Manager, ICICI Bank, New Delhi, (India)

Participants voiced concerns about private insurance players wresting control of the rural insurance market from the public sector, and then "leaving" rural populations "high and dry".

Group 8: Corporate Social Responsibility
Recommendations

- CSR programs should have a vision, starting small with employees and gradually expanding to families and communities around them.
- ILO Code of Practice can be used for HIV/AIDS workplace policy and program.
- Follow ILO specifications of a internal representative committee to monitor CSR at workplace.
- Institutionalize the program to build in long-term sustainability.
- Partnership, particularly public-private partnership, is the key
- Corporate –NGO partnership has potential. E.g. Modicare, Bajaj, Gujarat Ambuja.
- Facilitate pilots in health insurance in partnership with Government.
- CSR work plan should have clear, measurable indicators.
- CSR efforts can be given recognition (e.g. ASO accreditation in Thailand)
- Even small and medium companies can contribute by utilizing their core competencies
- Apart from funds, companies can contribute their management skill and technical expertise.

A contentious discussion broke out on what constitutes CSR. It was eventually decided to define CSR as corporate responsibility towards employees, their families and communities around them in address social-development issues like health, education and the environment.

Participants said that corporate organizations should show commitment by allocating funds and infrastructure required. The group recommended that the governments should institute ILO recommendations for setting up internal representative committees to monitor CSR at the workplace, whereby companies could ensure long-term sustainability of CSR programs.

It also suggested that building partnerships, particularly public-private partnerships, is essential, and that the corporate sector should facilitate pilot projects in health insurance in partnership with governments.

CSR work-plans, it was proposed, should have clear and measurable indicators. The group also recommended that genuine and effective CSR efforts be given public recognition. Small companies could contribute to CSR in their area of core competency and companies could look beyond funding, and even contribute their managerial and technical expertise for social causes.

Group 9: Engagement of Partners

Presentations on 'Faith-based leadership' and 'Collaboration with Private Practitioners' (which focused on field experiences in the Philippines) set the tone for the discussion on engaging partners that form strategic alliances and are powerful and critical tool for prevention, care and advocacy.

It was further contended that involving people living with HIV in prevention and counseling efforts brings a new meaning to partnership.

While the role for each partner has to be clearly defined, a mix is critical but there is currently a disconnection between public and private health practitioners. Instances like the DOTS-plus initiative in the Philippines should be considered as exemplary. Donor-driven partnerships create imbalances, it was argued, as much as scarce resources do.

Group 9: Engagement of Partners

Recommendations

- Private practitioners need to be sensitized to the aims of public healthcare.
- Private practitioners need to be informed and educated about public healthcare programs such as DOTS; this could be done also by incorporating public healthcare issues in the curriculum of medical colleges.
- Community members need to be fully informed and educated about healthcare programs and issues.
- DOTS and HIV treatment centers need to be made patient-friendly; engaging social workers from NGOs would help; social workers could be engaged in follow-up work, motivating and counseling patients.
- Donors and CCM should identify CBOs working in remote and hard-to-reach areas by collaborating with umbrella organizations that help reach out to these grassroots organizations.

Group 10: Strategies for Children and Other Highly Vulnerable Groups

The session was grounded in presentations on 'Triple Diseases in Tribal Areas: Perspectives, Practices and Grassroots Reflections from Experiences of Inter-State Cross-Border Regions' and 'Effective Services and Strategies for Children Living with HIV', which made a strong case for continuum of care – from home-based to institutional care – for vulnerable population groups.

It was argued that it is critically important to provide safety nets for the vulnerable – and neglected – sections of people. A holistic approach, including daily care, nutrition and education, can ensure a high quality of life for children. Effective services and strategies with a holistic approach need to become widespread. Rather than one organization aiming to scale up, it was suggested that organizations should attempt to 'scale out', by training a large number of other organizations to take up similar work.

The need for sharing information and lessons from successful experiences was emphatically stated so that the model can be replicated through training modules and appropriate publicity.

The special vulnerability of population groups such as tribal communities in remote areas was also described in detail, with specific references to the situation in the tribal areas on the Jharkhand-Orissa border in India. The utter lack of healthcare services is aggravated by the lack of outreach and absence of linkages with civil society groups, panchayati raj institutions and self-help groups.

A holistic approach, including daily care, nutrition and education, can ensure a high quality of life for children. Effective services and strategies with a holistic approach need to become widespread.

Detection of HIV is low, while there is a high likelihood of hidden infections. Funds provided for healthcare services are under-utilized and, paradoxically, often returned to the state exchequer. Seasonal migration is high, further aggravating risk of infection.

It was argued that good governance and community engagement in development activities are critical; linked to this, there is a need for building management capacities at the local level.

In the discussion that followed, various obstacles in the outreach of healthcare services to vulnerable groups (including tribal and migrant populations and children) were detailed. Donor hostility to fund long-term care programs was flagged as a big problem.

For tribal areas, the focus of discussion was on ways to build up healthcare facilities. It was suggested that migration patterns of tribal workers should be mapped, and healthcare services provided at points of entry as well as exit. There was consensus on the need to train local community members in disease detection and management aspects, especially youth, women and SHG members.

For vulnerable children, particularly for those children who do not have any homes, institutional care is important, it was argued. However, institutional care is resource-intensive, and donors are unwilling to provide for it. The governments do not have policies to support care of such vulnerable children, nor do donor agencies see it as a worthy cause.

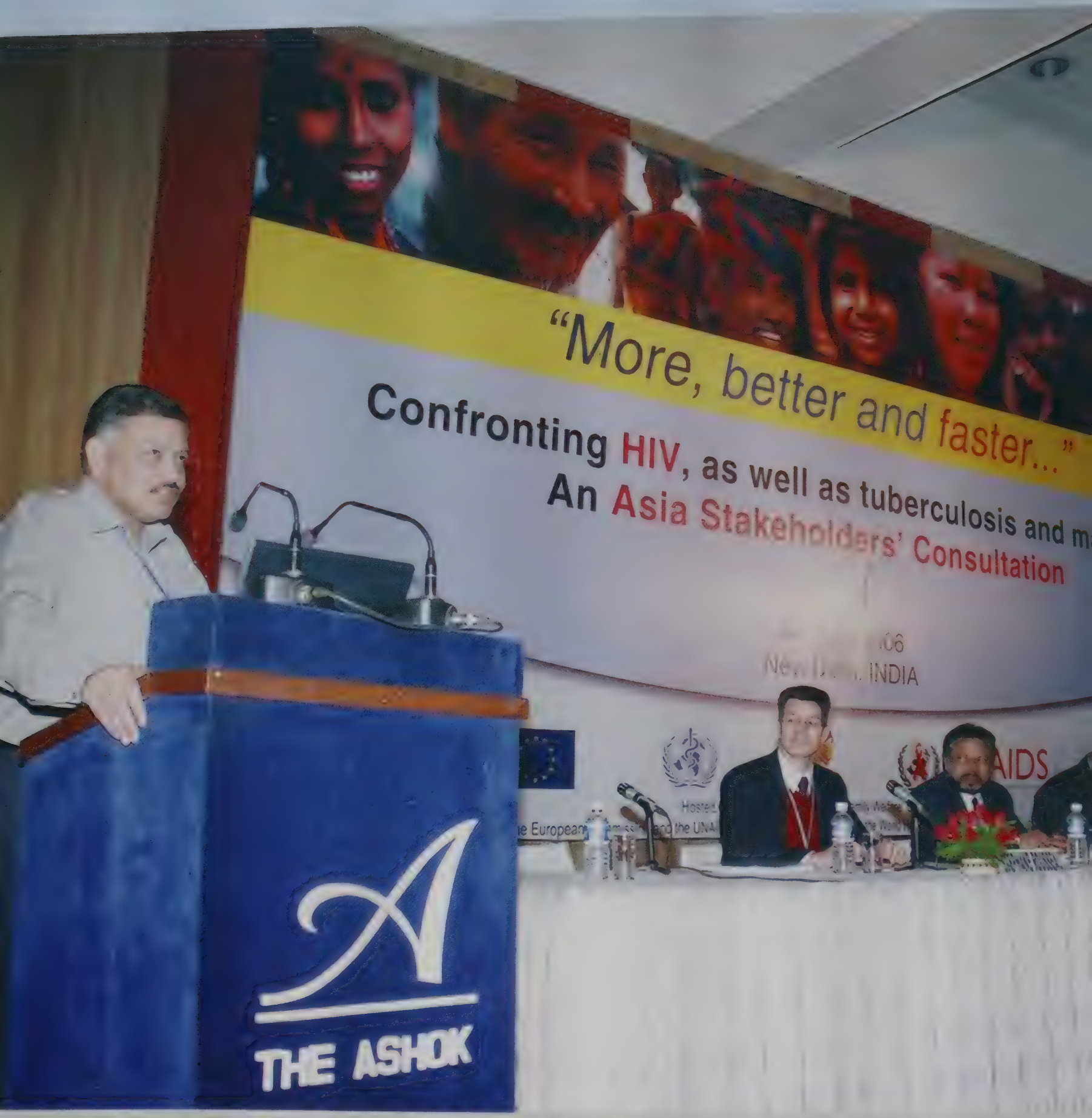
Discussion focused at length on issues surrounding acceptance of HIV-infected children, combating social stigma, informing children of their status – how, and by whom, sexual abuse and protection of children in institutional care.

Group 10: Strategies for Children and Other Highly Vulnerable Groups
Recommendations

- An exercise for mapping the status of vulnerable children should be undertaken.
- Continuum of care from home-based to institutional care should be formalized.
- Resources should be specifically earmarked for vulnerable children (affected and infected).
- Paediatric formulations for HIV and TB should be made available.
- Involve children and other vulnerable groups in programs through peer groups.
- Harmonize services at entry and exit points for migrant workers.
- Institute mobile and high quality health services for migrant workers, tribal people and such other vulnerable groups.
- Improved governance and involvement of local community groups are imperatives.
- Monitoring and evaluation of programs for children and for tribal and migrant groups must be undertaken periodically to assess quality of the programs and to further improve them.

April 7
PLENARY 6

Focus on Policy Issues



Mr AP Singh, Director(DC), Ministry of Health and Family Welfare, Government of India making his presentation while other members on the panel look on. (From left: Dr Stephane Rousseau, WHO, Mr Aminul Bhuiyan, Government of Bangladesh, and chair Dr B Zeferio, Member of Parliament, Papua New Guinea.

Focus on Policy Issues

Chaired by Papua New Guinea Member of Parliament Dr B Zzeferio, the session began with a presentation by Mr Muhammad Aminul Islam Bhuiyan of the Ministry of Health, Government of Bangladesh. Speaking on the Bangladesh National Health System, Mr Bhuiyan highlighted lessons learnt in communications, commitment and capacity building in the course of implementing the Health, Nutrition and Population Sector Program. The national system includes components of TB control, a national HIV/AIDS program and safe blood transfusion, as well as prevention of communicable diseases, including malaria.

He emphasized the need for leadership by government in policy making and planning, and the need for donors to have clearly defined roles. The sector-wide approach (SWAP) employed in Bangladesh, he said, specifically emphasizes capacity building. Efficient personnel management, improvement in procurement and financial management, he said, need focus. Collaborations between government and NGOs and between NGOs and the private sector, as well as judicious disbursements of pool-funds are imperative for a successful program, he added.

Dr Surajit Sonthorntham of the Thailand Ministry of Public Health made a presentation on the successes of the insurance schemes in Thailand. He began by explaining the 30-baht Scheme (general insurance scheme), the Civil Servant Scheme and the Social Security Scheme which are the constituents of the country's universal healthcare program. He went on to elaborate that a system of electronic money, a policy ensuring health care as a public right, along with a structure that puts the best person in the right place for the right job are the key ingredients contributing to Thailand's success.

The other crucial components of the success included the separation of provider and purchaser as well as an accreditation agency, he added. 'Population identification', evidence-based practice guidelines, and a routine reporting and feedback loop are some important features of recent reforms in disease management. The Thai experience, which has focused on HIV, has shown results – among other successes, it has achieved universal coverage in ARV drugs availability. The HIV prevention campaign also reaches people of all ages.

The impetus of healthcare sector reforms is on inequity and inefficiency. Further, diagnosis and counseling accessibility, routing CD4 test in asymptomatic patients, promotion of ARV drug adherence and controlling the spread of HIV between patients have received specific attention, as has the promotion of condom use. Thailand plans to expand its disease management program to include TB.

Mr AP Singh, Director for Donor Coordination in the Ministry of Health, Government of India, explained the working of the country's National Rural Health Mission, launched close to a year ago. Calling it a political initiative, he said that while India has successfully reduced the incidence of malaria and TB in the past four decades through several national programs, it has a plethora of

Getting a 'buy-in' from business and commercial interests implies 'mainstreaming' the concerned issues. "If we don't get the message out at the workplace we don't get it out at all," the ILO spokesperson said, a statement strongly endorsed by all participants.

vertical healthcare programs ... and a growing alienation towards these health programs "as one goes from the center through the state to the grassroots".

The NRHM, he explained, is an attempt at integrating various healthcare programs through the services of a community activist (accredited social health activist, ASHA). This, he explained, is designed to also bring about much-needed decentralization. A business administration management (MBA) professional and an information technology (IT) professional are being appointed in each district to provide professional support to medical personnel.

Mr Stéphane Rousseau, WHO Regional Coordinator for Global Fund (GFATM) issues at the WHO Western Pacific Regional Office, made a presentation on 'Reporting Constraints'. In general, poor data collection, poor reliability of data, time constraints, constraints of required managerial support, low motivation among reporters, poor national monitoring and evaluating frameworks, neglect in planning and budgeting, and difficulties in identifying an optimal number of indicators are some of the major problems, he said. The Global Fund reporting requirement, he explained, is sizeable and imposes a significant workload on managers. The problem is growing with multi-grant management. Solutions to alleviate this workload include an actual implementation of the harmonization and standardization policies of which Global Fund is a signatory (Paris Declaration on Aid Effectiveness notably). The gap between the Global Fund principles and their implementation in the field is a significant problem, he commented.

Breakout Group Discussions

Group 1: Convergence and Integration

The session took off with presentations on 'Mainstreaming in Non-Health Sectors' (which focused on ILO initiatives with the corporate sector), and on specific examples of public and private initiatives in health care, respectively in treatment and prevention of TB in India and of HIV in Sri Lanka.

Describing the elements of the interventions, the presentations highlighted the importance of intensive sensitization and awareness-building initiatives and extensive expansion efforts. The need for technical expertise – if necessary, involving external professional assistance – was also emphasized, as – repeatedly and emphatically – was the fact that getting a 'buy-in' from business and commercial interests implies 'mainstreaming' the concerned issues. "If we don't get the message out at the workplace, we don't get it out at all," the ILO spokesperson said, a statement strongly endorsed by all participants.

In the discussion that followed, the merits of a sector-based approach were highlighted; participants emphasized the need to reach out to the non-formal sectors, especially as these are significantly large in the developing countries of Asia.

Participants dwelt at great length on comparisons of the vertical services in TB and malaria treatment being provided currently in India, and the nature of convergence and integration being proposed by the relatively new National Rural Health Mission (NRHM) program. It was pointed out that India is attempting to merge three vertical programs – TB, malaria control and HIV – into a single horizontally

integrated service through the NRHM. Participants – among them, service providers who have been closely involved in the management of these programs – emphatically pointed out that the programs have had enormous successes primarily because they were vertically managed. They acknowledged, however, that integration would achieve economies of scale, cautioning nevertheless that this must not be at the cost of the effectiveness of the programs. Participants also accepted that integration could help bring the focus on the right aspects of healthcare services.

Convergence has implications more for non-health sectors such as education, employment, poverty and so on, rather than on the nature and epidemiology of the disease itself.

At the same time, it was suggested that more study about the integration of the DOTS program into the primary health care system is needed; the program is being increasingly integrated and yet reports significant effectiveness. With regard to the NRHM, it was suggested that more evaluation is required of the effectiveness and selection of the ASHA (Accredited Social Health Activist). More study is also required, it was argued, on whether integration – "a one-stop service" – would help mainstream services or retard the process.

Concerns were also expressed about the eligibility criteria for choosing the ASHA volunteers, the impact of the NRHM on marginalized population groups that do not have easy access to the public primary healthcare system, and issues of accountability and reporting on specific programs.

Discussions focused on specific aspects of integration such as technical and human capabilities, emphasizing that integration involves huge managerial challenges. Participants also focused on the implications of convergence and integration for monitoring, and repeatedly emphasized that while service delivery may be converged, monitoring – including budget monitoring – must remain vertical. Without this, they stressed, the delivery focus required for specific diseases would be lost.

Convergence has implications more on non-health sectors such as education, employment, poverty and so on, rather than on the nature and epidemiology of the disease itself. Mainstreaming of healthcare services would be influenced by the private and not-for-profit sectors, which have robust systems and structures and provide valuable conduits for health-related inputs.

Group 1: Group on Convergence and Integration
Recommendations

- Clear national policies and protocols, and national leadership are necessary conditions for convergence. But the sector managers need to be convinced of effectiveness of the program and spin-offs.
- Integration is possible if
  - Systems for quality assurance of all components are in place
  - Human resources and capacities are adequate to the demands of the program.
- Integration should be effected gradually and after adequate management capacities are built.

Integration that does not Address these Components is not Recommended

- Interventions need not be health driven but other sectors can have their own program to deal with same issues.
- Integration has to happen somewhere in the system. That makes it more cost effective.
- Leadership must also come from civil society.

Other observations and recommendations of the group were:

- Enhance workplace protection through means such as promoting condom use.
- Governments and corporate organizations should be encouraged to work with ILO to draw up a policy to address workplace needs.
- A model for involving medical professionals and laboratory facilities into the integrated service needs to be blueprinted. This is a challenge before service delivery managers and other technical and non-technical professionals. Similarly, training modules for all involved functionaries needs to be drawn up. Technical assistance from international partners should be sought in these processes.
- The minute details of integration of the public health program should be worked out at the local level, while government should drive the policy and program design.

The group laid down certain caveats for integration. These specified that:

- Integration must assure that alternate structures are in place to meet the needs of populations and regions not covered by mainstream providers – people in such as tribal and remote areas, high-risk, 'criminalized' and marginalized groups, such as intravenous drug users, men who have sex with men and commercial sex workers;
- Critical components such as earmarked funding, specific drugs, monitoring and reporting mechanisms of the vertical programs must be preserved.

The group concluded by strongly recommending that integration that does not address these components is not recommended.

Group 2: Health Sector Reform

The Group on Health Sector Reform set the discussion rolling with presentations on 'Pyramid of Capacity Needs', which focused on the ECTA-facilitated health sector reform at the primary level in India, 'Community Engagement Strategies for Better State Accountability' and 'Role of the ASHA, Community Health Volunteer, National Rural Health Mission'.

Following detailed narratives of field experiences in Bangladesh (in engendering accountability through community action) and the NRHM program, the pyramid model for reform was applied to show how the process of change is impacted by the structure, roles and systems at the base.

It was pointed out that capacity is often regarded as being synonymous with training. However, it needs to be more structured. A model of such a pyramid was presented – in which level 1 was the equipment for hospital, level 2 training, level 3 staff and infrastructure and level 4 structures, roles and systems – showing it works efficiently at the top levels, if the problems at the lower levels are addressed effectively. The model proposes making structural capacity effective through decentralization; similarly, role capacities also translate into greater effectiveness with decentralized powers.

The model proposes making structural capacity effective through decentralization; similarly, role capacities also translate into greater effectiveness with decentralized powers.

This model for developing management capacity could be applied at all levels, in working with *gram panchayats*, the private sector, NGOs as well as the government – getting everyone to the same table to work out logistics, supply systems and financial management.

The objective is to maximize the efficiency of all investments in health. If rendered effective, it could make the National Rural Health Mission a success.

In the discussion that followed, the major points raised were:

- A comprehensive integrated program is needed for South Asia that addresses cross-border transmission of infections.
- Implementers at the ground level need support. There are many excellent policies but the obstacles arise in implementation. Not enough attention is being paid to middle-level management, which is responsible for implementing the policy on the ground. Middle management structures must be reviewed.
- Block and district-level management committees should wield financial control, so that doctors can spend allocated funds on what they need for their facilities at the district or block level. Service providers, including doctors, must be made accountable to the community, particularly to the local government bodies (*gram panchayats*). As a first step towards this, disclosure of information should be made mandatory.
- More study is required to understand how participatory is the model of capacity building at the bottom of pyramid, and whether the training is imposed by donor-driven designs.
- Donors should coordinate efforts so as to avoid duplication and compartmentalization in state-level health reform. Donors, NGOs and other civil society organizations should meet at one table with the government to avoid duplication in efforts.
- Donors and facilitators should not simply be concerned with utilization of their investment, but also facilitate utilization of the state budget, respecting the perspective of the state.
- The concerns of people from hard-to-reach areas are poorly reflected in the reform programs.

The following problems were perceived and listed:

- Non-availability of doctors; transfers used as a tool for punishment.
- Lack of quality service.
- Issues of access and equity.
- The poor need focused financial protection.
- There should be security of tenure of managers.
- Knowledge management – dissemination of information is inadequate.
- Accountability is poor at all levels.
- Poor referral and follow-up
- Issues of personnel hired on contract for programs not addressed.
- Decision-makers have poor understanding of grassroots problems.

Other recommendations of the Group were:

- Doctors be made accountable to the *gram panchayats*.
- Right to Information Act should be used as a monitoring tool.
- Long-term commitment to reform.
- States come up with district health plans, enable *panchayats* to contribute in formulating district health plans.

Group 2: Health Sector Reform
Recommendations

1. Governance and Accountability

- Monitor presence of a doctor at place of posting.
- Improve internal/external accountability – increase demand generation, grievance redressal system for the poor.
- Behavior change communication for health-service providers.
- Empower local governments.
- Empower marginalized communities.
- Mandatory disclosure of information.
- More attention to middle-level managers.
- Strong political commitment – SWOC analysis to policy makers.

2. Quality of Care

- Improve infrastructure.
- Transfer of skills to next level of service providers.

3. Human Resource Management

- Serving in rural areas mandatory for PG.
- Mobility support for field-level workers.

4. Community Participation

- Community participation starts from planning stage.
- Strengthen CBOs/SHGs to influence government decisions
  - Allocation of district funds should be planned keeping in mind need of the community, and not based on performance of hospitals in the district.
  - Invest in building/strengthening the village health and sanitation committee as well as PRIs with reference to planning and monitoring.
  - Facilitates utilization of state budgets.
  - Donor Programs must respect government perspectives.

Group 3: Human Resources

Presentations on 'AIDS Competence', 'Corporate Resources' and 'Making the Funds Work for the People' provided the basis for the discussions in this session.

The leaders argued for self-assessment of competence to deal with HIV issues within a human capacity development framework, specifying tools to evaluate core competencies within organizations, communities and families as well as in policy-making. Developing such competence, it was argued, would lead to effective strategic planning, help set specific targets and identify what knowledge to share, and what has to be learnt from others.

Based on the experiences of the National Thermal Power Corporation (NTPC), India, there was a detailed narration of measures that the corporate sector could implement as part of undertaking responsibility for welfare, health and basic needs of local communities.

A comprehensive presentation on how funds could be made to work for people emphasized the need for a code of ethics for doctors so that health care is provided to all, including disadvantaged sections. It also made a case for reduction of overhead administrative costs, transparent merit-based recruitment, incentive-based performance contracts, public budget monitoring and third-party audits.

In the subsequent discussion, the importance of in-service training and continuous capacity building of health service personnel was emphasized, as was the need for increased accountability through social audits, public hearings, work-plans, and improved governance. The need for improving management skills at every level was stressed.

Some participants suggested that the words 'competencies' and 'core competencies' should be used rather than 'skills', and that specific competencies required for the task at hand should be detailed together with a plan for how to build those competencies.

It was emphasized that there is need for building competencies in governance, which is a weak functional area.

For developing accountability, clear record keeping was suggested as an essential tool. Self-assessment as a tool was strongly proposed for evaluating existing competencies and the need to further plan and fill gaps. Accountability can also be ensured through social audits as in public hearings (India). Work plans, improved governance and improved management at all levels would also help in assuring accountability and transparency. The need for sociologists in healthcare programs was brought up as necessary, for they can ensure cultural acceptance which technical personnel cannot always ensure.

Accountability can also be ensured through social audits as in Public Hearings (India). Work plans, improved governance and improved management at all levels would also help in assuring accountability and transparency. The need for sociologists in healthcare programs was brought up as very essential, for they can ensure cultural acceptance which technical personnel cannot always ensure.

A code of ethics for doctors and other health personnel was suggested, so that the disadvantaged and poor actually are not left out. Participants also agreed that overhead costs of governmental and non-governmental administrative machinery should be kept to a minimum, so that program funds actually reach target groups and service delivery becomes a reality.

Participants agreed that there should be merit-based transparent recruitment of health personnel at every level. Financial systems and structures should also be transparent. Working conditions of health personnel emerged as an area of common concern across the region, with a participant saying some trained healthcare workers receive as little as 20 US dollars per month. ASHA workers who are the backbone of India's primary healthcare system under the current strategy are paid a mere honorarium rather than a salary. The same is true for ANMs (Auxiliary Nurse-Midwives) and AWW (Anganwadi Workers) who have been the grassroots providers of health services to women and children for the past few decades. Participants expressed concern that unless working conditions are improved for health workers, services cannot possibly reach the vulnerable sections in a proper and streamlined way.

Group 3: Human Resources
Recommendations

- That local government human-resource plans be clear on required competencies and deliverables in terms of:
  1. Number of staff and levels
  2. Their division of labor and accountability
  3. Quality of service deliverable
  4. Expectations of the clients
  5. Mechanisms to retain the recruited staff
- That there be investment in raising local community competencies in planning and monitoring the health services, qualitatively and quantitatively, especially in terms of accountability and governance.
- That there be investment to promote locally adapted self-assessment principles and tools for evaluating core competencies to support self-improvement, learning and sharing.

Discussion at the subsequent Plenary brought up importance of human resources in terms of local self-governance and the critical need to retain human resources within the healthcare system.

Group 4: Financial Resources

The group based its discussions on presentations on 'Financial Resources Gaps and Making the Money Work', 'Strengthening Micro Health Insurance for the Poor in India' and 'Government's Percentage'.

The presentations highlighted the glaring gap between the financial resources needed in Asia over the next few years, for prevention, treatment and care of malaria, TB and HIV, and the current spending levels. The following data was presented:

Estimated Requirement for Asia	Current Available Resources
HIV/AIDS: US$ 15 bn (2006-8)	HIV/AIDS: US$ 5.1 bn
TB: US$ 11 bn (2006-2015)	TB: about US$ 5 bn
Malaria: US$ 700 million per year	Malaria: US$ 100 million

During discussion, participants emphasized the need for increased public-private partnership.

The recommendations – for donors, government and civil society – were that available resources should be effectively utilized, procedures simplified and accountability procedures built into the programs. It was also emphasized that financial disbursements should be expedited.

Group 5: Funding Mechanisms

The Group on Funding Mechanisms based its discussion on presentations by Mr Uwe Wissenbach, the European Commission Policy Desk Officer for Health, AIDS and Population (in the Social and Development Unit), Dr Taufique Rahman of the Global Fund to Fight AIDS, TB and Malaria and Dr Anabela Abreu of the World Bank. Each presented an overview of the funding mechanisms of their respective organizations, citing areas of concerns and possible solutions for the same.

Mr Wissenbach described the Commission's initiatives in investing in people, welcomed recommendations to better the funding mechanism. In his presentation on 'Accelerated implementation: issues and challenges of performance-based funding of the Global Fund', Mr Rahman explained the Global Fund's objective of accelerating coverage and impact, quoting success stories in TB and HIV health care from India and Bangladesh and in malaria from Bangladesh.

The group recommended the need for a commitment by the Global Fund and the governments (of respective countries) towards greater involvement of the civil society, and suggested the involvement of certain sub-recipients who can then associate more closely with CBOs in reaching out to the people. Colombia was cited as an example to elucidate how (government funded) programs implemented by the community themselves are more effective as well as sustainable.

Citing the example of the BRAC success story, the group also suggested a proactive donor involvement in the role of CCM and the formulation of active CCMs, which would not be dominated by the government. Other recommendations included the need for in-country regional and

Group 4: Financial Resources
Recommendations

The group recommended that the government should:

- Build political commitment which helps to seek additional allocation from government.
- Earmark resources for different diseases.
- Create insurance schemes in partnership with private sector to enhance coverage of the poor (including micro health insurance).
- Also, enhance coverage of health insurance, which would shift out-of-pocket spending to pooling, thereby benefiting members. It was suggested that governments could impose a cess on insurance providers, which could be used for enhancing the access of the poor to healthcare insurance.
- Build partnerships with suppliers to provide cheaper drugs to members.
- Separate the roles of purchaser and provider of health care.
- Increase advocacy with the private sector to provide support for issues like subsidizing costs of treatment, contributing to the national strategic plans on health care, and taking up workplace programs.

Recommendations to Donors

While the Global Fund was asked to consider investing in building capacity of recipients to utilize funding, recommendations for donors overall were that they should:

- Ensure effective coordination so as to strengthen the mechanism of supporting the national plans under the 'three ones'.
- Be flexible in funding and impose only reasonable conditionalities.
- Focus on all countries of the region; there was specific mention that Myanmar is not adequately covered.
- Effectively enforce the concept of matching grants with local response mobilization.

provincial CCM, the privatization of CCM and funds for the management of CCM. There was also a suggestion for distribution of funds at the constituency levels so the political leaders could plan region specific interventions for their areas.

Dr Abreu of the World Bank spoke of the need for understanding country-specific characteristics, and the dynamics of specific infectious diseases. She emphasized the need for technical assistance at government level to help prioritize objectives, design programs, plan performance-based budgets and so on. She recommended the extension of a similar technical assistance for civil society organizations, with inclusion of all these costs into project proposals.

She focused on the fact that in most cases the government views the civil society as its competitor rather than a vehicle to take the nation's cause forward. She recommended the need for technical assistance to bring both these institutions in consensus and in continuum with each other.

She also spoke of the problem of different funding agencies having different agendas. The group recommended the harmonization of donor agencies in terms of evaluation procedures, review missions and sharing of information. This was in tune with Mr Taufique's recommendation of funding agencies aligning with the national system for a donor joint review as well as a standardized and harmonized report plan.

A lot of emphasis was given by the group to the need for transparency, in performance for grants, working of the CCMs,

The group also suggested a proactive donor involvement in the role of CCM, the formulation of active CCMs, which would not be dominated by the government and would have key players from outside the government, citing the example of the BRAC success story.

selection of the civil society and NGOs being funded, etc. It was recognized that it was equally important to disseminate this information, especially in the case of success stories of CCMs with active participation by civil society, or successful government NGO collaboration. It was also pointed out that success stories of collaboration between the donor and different countries should be documented and circulated, especially with reference to their long-term interaction and how the relations were built over time. Another recommendation was that all available information should be put up on the donor's website to be made accessible to all.

Finally, summarizing the session's proceedings, Dr Anabela Abreu also recommended the need for technical assistance for the contracting arrangement between the donor and the principal recipient. The group took it forward in the discussion, emphasizing that the country coordinating mechanisms (CCMs) are not doing enough with available funds.

Group 6: Alignment and Harmonization

Focusing on issues of alignment and harmonization for more, better and faster convergence of HIV, TB and malaria control and treatment services, the session began with presentations on 'Health SWAP in Asia – What are We Learning from Experience?' and on 'Coordination: NGOs, Private Sector, Donors (The Three Ones)' and 'Implementation of Recommendations of the Global Task Team on Improved AIDS Coordination among Multilateral Institutions'.

Describing the concept of the sector-wise approach (SWAP), its key objectives, strategies and convergence in terms of regions and sectors, the first presentation explained that reforms were part of SWAP, which is basically a blueprint for a structure in support of a government-led reform agenda. It described the example of the Philippines, where SWAP had been adopted in order to achieve a better health insurance system. Similarly, in Bangladesh, the priority was to help the

Group 5: Funding Mechanisms
Recommendations

Recommendations for CCMs

- Have active CCMs that are not dominated by Governments, with greater participation from Civil Societies (Afghanistan Steering Committee, BRAC success story and the Philippines)
- Enhance CCM's oversight function – to consider programmatic implementation problems (focused more on the targets)
- Need for country, regional and provincial CCMs, if possible with privatization

Recommendations for Global Fund

- "It's not enough for Global Fund to say that we will not interfere with the Government processes; it is time they act on the problems".
- Take the lead in nominating sub-recipients within civil societies with greater outreach at the CBO level

Recommendations to Donors Supporting Global Fund

- Harmonization of donor agencies in terms of evaluation procedures, review missions and sharing of information
- Push Global Fund into proactive participation in CCMs
- Push transparency in CCMs, in selection processes and review financial and progress reports
- Make CCM meeting reports available on the GF website

Recommendations for Donors

- Stringent review and monitoring of CCM mechanisms, performance and effectiveness every year and sharing information with other stakeholders
- Quality TA
  - to Government to prioritize areas
  - contractual arrangements for the Government and the Civil Societies
  - capacity building at the CBO level

system to decentralize, ensure effective service delivery and improve the contracting-out system with NGOs.

The next presentation identified the challenges of achieving harmonization and alignment in dealing with imbalances perpetuated by monoliths, establishing ownership of national responses to HIV, dealing with token involvement and addressing capacities. It cited the example of Brazil where social control in the form of compulsory involvement of NGOs in government bodies had proved effective. The way ahead, it was argued, includes developing generic guidelines, strengthening communication systems and compiling a set of tools to facilitate collaborative planning for the 'Three Ones'.

The final presentation stressed the importance of increased funding for technical support. It argued for a funding mechanism for technical support providers, and participatory performance reviews of international partners and national stakeholders through public dissemination, score cards to measure stakeholder participation, partner performance and alignment and accountability mechanisms.

The open discussion began with a debate on the roles and responsibilities of the government, the civil society and the private sector. It was acknowledged that in certain countries, a strong civil society did not exist. In those where it did, there was a definite need to define the roles

Group 6: Alignment and Harmonization
Recommendations

- Having different mandates for different stakeholders.
- Facilitating a process to develop an understanding of the roles and responsibilities of stakeholders in the framework of the national response. Once the process is initiated, it would require that roles and responsibilities of these constituencies be allocated and resources identified and assigned.
- Establishing, supporting and strengthening representative civil society forums; this imperative need would also involve making available resources for building capacities of CSOs for meaningful involvement.
- Establishing 'ownership' of not just the government, but also of civil society.
- The need to work towards a broader definition and enhancement of role of civil society.
- Making civil society equal to other stakeholders.
- The review system should be truly representative of the various stakeholders, ensure mutual accountability and transparency and support communication and flow of information.
- In terms of sustainability of funding technical support and capacity, there is need to move away from a fire-fighting approach to a long-term strategic one.
- Costing technical support and capacity-building plans would go a long way in ensuring that the funding is sustained on the lines of the Global Task Team recommendations.
- As has been spelt out in the NACP-III framework, government funding needs to be ensured in addition to donor funds.
- Country-specific systems need to be clearly understood at the time of planning and implementation. It is imperative also to understand the country-specific political processes and systems in order to achieve harmony and align with the same. Recognizing the disparities and developing strategies to suit the country is imperative. The 'one size fits all' maxim has been clearly disproved.
- Development partners, including bilateral and multilateral institutions should establish clear coordination arrangements and mechanism. Establishing clear guidelines is a prerequisite for synchronization. Implementation of GTT recommendations in order to ensure the involvement of bilateral and multilateral institutions in national-level consultations is imperative.

and responsibilities of the government, civil society and the private sector. Even as civil society is fighting for space, there are encouraging examples, such as in India, where the civil society representation is significant both in policy formulation and program implementation as in the case of the National AIDS Control Program (NACP) III. Partnership forums were seen as key to developing harmony between the constituencies. It was also necessary that country-specific processes be recognized. Here, the success stories in Indonesia and Cambodia as a result of strong political commitment and strong civil society were mentioned. It was important to understand that in countries where access to public health services was low, NGOs complemented the role of the government.

It was agreed that country ownership and national ownership are not necessarily the same. While programs start out with the premise that the government is in the driving seat, it is necessary to ensure a participatory and democratic process. Recognizing that country ownership needs to include the government and the civil society (NGOs, private sector, CBOs, academia, unions, etc.) is a key step towards achieving harmonic relations between the government and the civil society.

Participants also agreed that there is a definite need to define the roles and responsibilities of civil society, and that the definition of 'civil society' itself needs to be spelt out. In addition, there is need to include representation of rural communities and marginalized groups in the networks, not only as beneficiaries but as potential sources for providing technical support and capacities.

The private sector role as that of provider, financier and as resource for managerial and corporate experience was acknowledged to pave the way for a clearer definition and better understanding.

A single evidence-based MIS was recommended for ensuring accountability and improving transparency. This could be used not only as a tool for reporting, but also to empower countries to enter into dialogue with partners with regard to funds, strategies, etc. National governments need to be supported in building such as system.

April 8

PLENARY 7

Concluding Session

Mr PK Hota, Secretary, Ministry of Health and Family Welfare, GoI, presents the certificate of attendance to a participant from Bangladesh as Mr Uwe Wissenbach, Policy Desk Officer, European Commission looks on

Concluding Session

The four-day Conference, which aimed at arriving at better knowledge and understanding of the issues concerned, recommendations for effective integration and convergence, and recommendations for immediate and future action, ended with a presentation of the draft recommendations by the European Commission Policy Desk Officer for Health, AIDS and Population (in the Social and Development Unit), Mr Uwe Wissenbach.

Emerging Issues

1. Intensify and expand work with CBOs in coordination and alignment with national policy.

Replicable model: Bangladesh self-help groups of sex workers, trans-gender organizations and truck drivers.

Results/Outcomes: Groups themselves did the mapping of problems and build capacity to address them, organized awareness raising and prevention, organized support through micro credits and other schemes. Prevalence among sex workers and truck drivers was less than 1 percent.

Scale: 5,000 sex workers, 100,000 truck drivers.

Advantages: helps the government map problems and reach out to those groups in a cost-effective way, enhance prevention and to some extent care and support among sex workers and clients.

2. Institutionalizing meaningful engagement of civil society and industry.

This needs to be a country-led intervention, with a central role for national and local governments; however, it is important to broaden 'national ownership' to include government, NGOs/CBOs, private sector, academia, unions, etc.

3. Funding community-centered operational research based on technically sound research protocols.

Such research is expected to generate much-needed evidence of health needs and interventions demonstrating what works and what does not.

4. Invest in promotion of locally adapted self-assessment principles and tools.

Invest and technically assist in the development and utilization of standardized and integrated monitoring and evaluation tools

These will help in the valuation of competencies in support of self-improvement, learning and sharing.

5. Support country-level systems for increased harmonization amongst different stakeholders in line with their specific mandates, roles and responsibilities.

Support and technically assist countries in harmonizing mandates, roles and responsibilities of different stakeholders. This includes collaboration between the different health programs (HIV, TB and malaria) to deliver quality health care services to co-infected patients.

6. Developing financing mechanisms to ensure equitable access to prevention, treatment and support.

Such mechanisms should be community-based and in partnership with the private sector to ensure health care for those who can least afford it.

Model: Thailand 30 baht card. To be studied further whether this model is replicable and sustainable in other (poor) countries.

Advantage: promotes independence from hand-out mode of funding.

7. Greater role for medical professionals and their organizations in prevention and supportive care.

These are the twin engines for containment of diseases/epidemics. The medical professional's focus is usually on care; prevention and support are neglected. They can play an equally significant role in prevention.

8. Law enforcement reforms for:

(i) Prevention and care for groups at risk

Replicable model: Kolkata police reform (IDUs) (and similar Europol program on combating human trafficking)

Results: Care given, prevention successes and generally lower crime rates linked to drugs; gain for police – success in fighting crime, better work environment.

Can be scaled up and replicated to cover other groups which are often subject to police abuse (sex workers, victims of trafficking, homosexual men and trans-gender), provided there is sustained commitment of police hierarchy, training for officers, trust and confidence building with community and partnership with CSO.

Can be linked to reform/abolishment of laws discriminating against particular groups of the population (sex workers, homosexual men, migrants and so on).

A commitment to law enforcement by governments is needed to ensure procurement and supply of quality medicines to fight HIV, tuberculosis and malaria, and with respect to counterfeit drugs.

(ii) Holistic inmate-centered prison management

The aim is reintegration in society and focus on preventing HIV, TB, intravenous drug use, etc. as well as treatment and care. Notable features: Talking to inmates, mobile feedback box. Requires commitment and leadership by prison service hierarchy, possibly cooperation with an NGO partner.

9. Building capacity of regulatory agencies at all levels.

Substandard medicines are purchased as quality assurance systems are weak or absent; furthermore counterfeit medicines are circulated widely in Asia. Use of substandard or counterfeit medicines poses a health risk for patients and is a waste of money for the community as a whole.

A commitment to law enforcement by governments is needed to ensure procurement and supply of quality medicines to fight HIV, tuberculosis and malaria.

10. Cross-border collaboration efforts to be adequately supported.

Borders are high burden and transmission areas for malaria and need special attention such as coherent joint policies on drugs/treatment, prevention and control of outbreaks; extending delivery of interventions to marginalized populations.

Coordinate with other international donors, multilateral institutions and technical agencies in:

a. Avoiding duplication and compartmentalization of efforts at different levels of governance
b. Developing a standardized program monitoring and evaluation tools
c. Conducting joint country visits
d. Supporting, promoting and technically assisting country-led priorities in program agendas.

Presentation Ceremony

Mr PK Hota, Secretary, Union Ministry of Health and Family Welfare, Government of India, presented thanks to the organizers and participants for their contribution to the dialogue. He conclude comments with the remark that it is in India's interests to consider and act on the recommendations that emerge.

Participants were presented with certificates of appreciation for their contribution to the consultations, while sponsors received thanks and, in turn, expressed the confidence that the Asia Stakeholders' Consultation on Confronting HIV, tuberculosis and malaria would go a long way in addressing the prevention and care issues of the 'Big Three' – HIV, TB and malaria – with more, better and faster creative energies!

Recommendations

Cross section of the participants from the various parallel group sessions

Introduction

The meeting which took place in New Delhi attracted over 300 participants from various countries in the Asia region. All had different sets of experience and organizational settings. Government representatives worked with disease experts, civil society organizations, members of several development partner agencies, persons living with the disease, private entrepreneurs and staff of international organizations. Working groups gathered every day to synthesize recommendations from discussions and presentations made. The wealth of wisdom and knowledge produced during the Consultation cannot receive full justice in this document, which summarizes the main recommendations produced during these four days.

Several general recommendations were made during the meeting and are not examined in detail here, as they could apply to any other meeting: recommendations on the importance of involving all stakeholders, holding wide consultations, working in a collaborative manner, supporting the poor, acting on the strength of evidence, sharing documentation, etc. Although very relevant, and not only in the context of the Consultation, these recommendations do not require to be examined in detail in these proceedings. Country specific recommendations are also not examined separately in this document.

The current document looks into the recommendations of the Consultation broken down into the following categories:

- Cross-cutting recommendations pertaining to policy issues, structural and systemic issues and financial issues
- Disease-specific recommendations
- Recommendations on the research agenda
- Specific recommendations addressed to the European Commission and other development partners

Cross-cutting recommendations apply to all three diseases, most or all Asian countries and most or all stakeholders. Disease-specific recommendations are numerous, and are separately listed for malaria, tuberculosis and HIV. The consequences of these recommendations for the European Union and other development partners are also identified. An important set of recommendations was made regarding the research agenda in Asia. Specific recommendations addressed to the European Union, other donors and development partners and stakeholders were regrouped in one last category.

I. Cross-cutting recommendations

Policy Issues

1. Make sure interventions are targeted

The Consultation emphasized that programs addressing any of the three diseases should ensure relevant and targeted interventions that would first reach peoples in the greatest need. The importance of appropriate geographic and socio-economic mapping of populations requiring interventions in priority should be the first step in the design of programs. Targeting provides an identification of populations needing services most urgently and guarantees efficiency of their delivery, if they are adapted to the specific needs.

On targeted interventions, the Consultation advocated for program flexibility. Programs should be tailored to the needs of specific communities. "One-size-fits-all" programs should be avoided, even if one single national strategic framework defines the overall approach of these programs. This is particularly true for HIV prevention, where groups at high risk may have very variable needs from one area to another and from one socio-economic group to another.

The Consultation stated the importance of affirmative action and outreach programs. High-risk populations, isolated communities and very poor communities have different service needs and are often reluctant to access mainstream services. They need specific programs for their specific conditions. For these groups, services need to go to them, not the other way round. Policies to improve this service delivery may utilize specific subsidies, and market support mechanisms for such communities to create some form of "public health affirmative action" in favour of these specific populations.

Obstacles may include laws, regulations and government policies alienating or not recognizing the existence of high-risk groups, such as MSM, sex workers, migrant workers or ethnic minorities[1]. These need to be addressed. Other obstacles pertain to stigma and discrimination, which hamper the delivery of interventions, in particular for TB and HIV. Civil society organizations have to particularly concentrate on support to these marginal groups, which may be left out of general programs.

Consequence for the EU and other development partners

Specific funding for programs addressing the needs of specific populations may be fully justified, even in the context of support to health reform processes. Donors may consider financing specific studies to identify most at-risk populations, identify their specific needs and prepare specific programs that would support them efficiently.

For development partners this may be a difficult task, as there may be local political pressure for them to address "mainstream populations" instead. In addition, the Consultation identified that certain donors (in particular the US Government) have conditions on utilization of their support that may increase the difficulty to reach certain populations, notably sex workers. The importance for donors to make sure their funds first address the needs of populations most at risk, even if they are remote or marginalized, has to translate into affirmed positions that have to be central in the policy dialogue with governments.

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[1] For instance, India does not collect cast or tribe information from patients with HIV and little data is available about the risk factors of these groups.

2. Define and scale up essential service packages

The Consultation recommended that governments should define simple and targeted packages first, tested in the field and scaled up. Expansion inside an integrated health system should come at a later stage. The expansion from essential to comprehensive services should only be a second step, once the first service packages are in place and delivered to populations needing them. Then, governments should gradually expand the number and types of services to a comprehensive package of intervention, as resources, systems, legislation and awareness levels grow. The approach was defined as "start small, simple and low-cost".

Concentrating on populations and areas in the greatest need requires that the small, simple, and low-cost package be tested for delivery in different places where access is a major issue. Success in delivering the essential package is a prerequisite to expansion. It requires the engagement of existing public and private service providers in the locations most in need, including non formal providers, and a strong coordination of service delivery by the government. Essential packages can often be implemented in part by community volunteers, provided they receive adequate training and support.

The expansion of the package of services can happen gradually, based on the effective implementation of the minimum package.

Consequence for the EU and other development partners

The quality of dialogue with policy makers is very important. Several national programs (Malaria, TB, HIV) have defined a package of essential services, however, for countries without such programs the use of WHO guidelines and recommendations can be promoted by development partners. Clarification is needed from policy-makers to enrich this dialogue and arrive at an appropriate package of "essential support".

The Consultation made a difference between the essential package of services (prevention, care and support, treatment) and the comprehensive package of interventions (which also includes surveillance, M&E, research, advocacy, training and systems support). It was felt that guidelines were needed on how to implement the essential packages and how to gradually evolve from one stage (essential) to the other (comprehensive).

It was also advised that development partners request the governments to set up guidelines on the roles of the different service providers and stakeholders involved, the role of communities and people living with the disease and the financial mechanisms of their interaction. Without such information, there is a risk for development partners to support 'non essential services' that do not correspond to the national essential package.

3. Integration and convergence of programs

The Consultation acknowledged the need to optimize integration and convergence of HIV, TB and Malaria programs within the primary healthcare delivery system[2]. Convergence was found to be an important mechanism to increase cost-effectiveness and sustainability of interventions. However, participants agreed that a certain degree of "verticality" was needed for the disease programs.

[2] The example of the National Rural Health Mission in India was provided

- **Optimize resources and increase accessibility through integration/convergence**

Some integration and/or convergence between vertical and horizontal health programs is necessary in order to optimize scarce resources available, and to increase accessibility to services. Integration and convergence of programs and systems make it easier for people to access different types of services. Otherwise, a confusing multiplicity of programs with differing requirements and offerings retard their basic purposes and goals. There needs to be a complementary approach to horizontal and vertical programs and systems. For instance, integration was found particularly useful at community level, in primary care, in laboratories and referral services, and for the best utilization of support and maintenance services

- **Retain necessary verticality**

However, the Consultation found that programs do need to maintain a certain level of verticality, for a number of reasons - monitoring, treatment compliance and performance, confidentiality, and the specificity of certain communities, who are unable or unwilling to merge with mainstream society in mainstream public health services. In addition, specific training programs have to be conducted, specialized supervision and evaluation performed and specific activities monitored.

Consequence for the EU and other development partners

Convergence has to appear in programs supported by development partners: support to "health systems reform" must include assistance to specific vertical programs, which have to find their place in the overall reform approach. Conversely, support to disease specific programs should have a systemic component and explicitly avoid parallel systems that make health management costlier and more complex (parallel procurement or supply chain management to TB drugs, for instance).

Improvements generated through vertical programs must benefit the whole health system and not create large discrepancies between facilities or within facilities. Examples were given during the meeting: laboratory services (district hospitals with a brand new CD4 machine and ELISA reader but where the laboratory cannot perform a blood sugar test or operate a functional microscope), civil works (TB clinics with new buildings and comfortable waiting areas whereas the rest of the facility was decrepit and in need of repair) and human resources (financial incentives and training opportunities provided to certain categories of personnel working on a vertical program and not to others).

4. Review tripartite partnerships

Existing tripartite partnerships (Donor – intermediary CSO – CBO) need to be reviewed in order to realign roles and to strengthen existing community-based systems, structures and services. Alternative mechanisms may also have to be explored.

A very clear and repeated call in the conference was for donors to support and fund CBOs, including self-help groups of key communities like sex-workers, MSM and intravenous drug users, who fall outside mainstream government policies and healthcare access. Community based interventions have proved to have a strong and lasting effect and are particularly cost-effective.

As the Consultation clarified, larger donors cannot directly fund small-scale self-help groups. Smaller private foundations, UN organizations, international NGOs or "small donors" can. Most self-help groups often function informally, use local language(s) and are not structured to manage cumbersome bureaucratic procedures.

As there is a clear call for support to CBOs, new mechanisms to ensure a better functioning of tripartite partnerships have to be found. CBOs need to work with intermediaries such as NGOs, CSOs, UN organizations, government programs, faith-based organizations, issue-based networks and mentors in order to receive funding from large donors.

Several replicable models exist: Bangladesh self-help groups of sex workers, organizations of trans-gender groups and truck drivers. The groups did the mapping of problems themselves, engaged in capacity building, organized awareness raising and prevention, help and support through micro credits and other schemes. The result was that prevalence among sex workers and truck drivers fell to less than one percent. An Indian NGO supporting MSM established a network of CBOs that it supports with management assistance, training and regular supervision with excellent results.

Consequence for the EU and other development partners

Apart from the review of the tripartite system, there is a need to analyze why there appears to be a problem in the channelling of funds to the grassroots level, and to review the timeliness and efficacy of financial supports. Development partners need to provide funds in coordination with the government guidelines, and concentrate on mechanisms that allow CBOs to deliver the services for which they are best adapted. Strengthening capacity in management, accounting or complex reporting should not be the priority of donors with CBOs. Development partners should concentrate on results and cost-effectiveness of prevention, care and support of CBOs.

In addition, the Consultation recommended that development partners make sure there is clarity in the mandate and roles of the three partners of tripartite agreements with clear delineation also of expectations, and available resources.

It is necessary to be precise about the mandate, role and available resources of each set of stakeholders at the three levels. Only then can one expect effective partnerships that can contribute to reaching universal access to essential services, and an improved protection of people and communities' legal rights.

5. Support legal reforms

The Consultation made one recommendation on legal reform applicable to the three diseases: the full implementation of national regulations on pharmaceutical registration, manufacture, quality control, procurement and distribution. In addition, the Consultation recommended that specific measures be taken to fight the menace of counterfeit drug.

Other recommendations from the Consultation on legal reform mostly related to HIV/AIDS. High-risk groups such as sex workers, MSM or IDUs are often technically outside government intervention due to legal barriers. Same sex relations are considered a crime under the penal code of several Asian countries. Legislative reforms are necessary in order to bring them mainstream healthcare access.

Section 377 of the Penal Code, for instance, outlaws homosexuality, shutting the doors on a large high-risk group in India, Pakistan, Myanmar, Malaysia and Singapore. Still, replicable models, even within the current legal framework, exist. Such as the participation of the Kolkata Police in helping IDUs with exchange of sterilized needles.

The Consultation recommended that legislative changes be brought after a wide consultative process including all stakeholders, based on sound scientific evidence (this has been the case for

the introduction of harm reduction by decree in Iran), and involve intense political and media advocacy. The Consultation recommended that mechanisms for enforcement of the law be in place and harmonization across borders be encouraged to the extent possible. It also recommended that state/provincial legislations be harmonized with the national policy.

Consequence for the EU and other development partners

Development partners cannot be directly involved in the legislative process of another country and should make sure that their support to legislative change remains within the scope of normal inter-country relations. The Consultation has recommended that development partners support civil society organizations in their efforts to overcome the discrepancies in the approach of government institutions (HIV authority issues guidelines on support to MSM whereas Home Ministry organizes repression of the same).

Development partners can support civil society organizations with training on legal reform and political advocacy, communication tools and forums to debate with policy makers about the issues of marginalized groups. The support of models brought by international organizations can also be mobilized by development partners (UNAIDS on discrimination, ILO on HIV in the work place, etc.).

Development partners can support countries for the adequate enforcement of pharmaceutical regulations and fight against counterfeit, fake and spurious drugs. Support for training of inspectors both for manufacturers and distributors, equipment and management of quality control laboratories are mechanisms that development partners can use. In addition, support to the prequalification process of WHO also helps in improving the quality of pharmaceuticals used for the three diseases.

6. Mobilization of private resources

The Consultation recommended that the role of large corporations and private industry as a whole in the control of HIV, TB and Malaria needs to be examined. Several presentations showed significant and effective efforts made by specific corporations to support programs addressing the three diseases, but no systemic approach could be drawn.

The Consultation estimated that corporate social responsibility needed to be more clearly defined and worked out. Globally, the Global Fund has failed so far to attract a significant share of resources from the corporate/private sector worldwide. From end 2002 till May 2006, the private sector has only provided 3.3 percent of the total funds received by the Global Fund (US$ 166 million out of 5 billion), although support to the Global Fund where the private sector has a Board representation is one of the most cost-effective for corporations because of low transaction costs.

In Asian countries, isolated cases exist of corporations with a comprehensive policy on HIV in the work place or comprehensive malaria prevention and care, but these are not generalized and enterprises still do not consider it their role to support large public health initiatives. The few corporate hospitals and health centers that provide prevention and care services in Asian countries play a very limited role, generally limited to the company's workers and their family.

However, the Consultation noted the initiatives taken by certain private sector organizations and enterprises: CII in India is one of the implementers of a Global Fund grant on HIV in India and contributes to the elaboration and testing of a smart card for AIDS patients, Indocement has a major corporate program of HIV prevention in Indonesia; Sumitomo (Japan) has a major

agreement for the supply of low-cost long lasting impregnated nets, etc. There are questions about the long-term sustainability of such programs and measurable indicators are often absent of these programs.

Consequence for the EU and other development partners

Development partners should be open to possibilities of co-financing for certain initiatives and should encourage NGOs working with their support to develop advocacy towards the corporate sector. They should also advocate the ILO code of practice about HIV in the workplace in their interactions with corporate executives. Development partners should also encourage civil society organizations to request pro bono managerial skills support from corporations willing to contribute to the fight against the three diseases.

7. Diagnostics

The Consultation recommended that a major effort be made to make sure early and dependable diagnosis is accessible to hard-to-reach populations. Policies should promote universal access to cheap and early testing for the three diseases. Hard-to-access populations need sufficiently sensitive early diagnosis tools. In practical terms the policy may have to opt for lower quality/sensitivity tools, especially in very remote areas.

The Consultation outlined the need to invest the following in order of priority:

(i) Make accessible of free or low-cost early diagnostic tools to be used by communities

(ii) Training communities in methods of prevention and early diagnosis. It may mean that the first early diagnostic "tool" (in the cases of TB and malaria) is the "ability" of these communities to detect and diagnose a likely infection.

(iii) Referral laboratories to confirm diagnosis in case of doubt.

The Consultation also recommended that diagnosis be widely available both in the public and private sector, and that the government establish quality control mechanisms for both sectors to contribute to the national effort to combat AIDS, TB and malaria.

Consequence for the EU and other development partners

Development partners should support the development of new, cheap and easy to use diagnostic tools, and their procurement. Access to free testing requires the appropriate level of financial subsidy, which has to be planned carefully as communication for promotion of testing increases demand for tests.

In all three diseases, but most particularly HIV, testing cannot happen in isolation and has to be integrated with proper pre and post test counseling. Integration of testing and counseling facilities is an absolute necessity to enforce this approach.

As mentioned, higher support to laboratories is required across the board in most Asian countries to provide the necessary level of technical reference. Training of laboratory technicians is required within integrated training curricula and as specialization training, especially for microscopic diagnosis of tuberculosis and resistance testing.

Structural Issues

1. Use existing systems

- **Use existing community-based systems, structures and services**
  Geographic or common-interest communities have systems and structures that can be utilized for health programs. It is important to first assess existing community structures, systems and services, before starting services.
- **Self-governance/Community leadership**
  Setting up new services should only take place after being assessed by the specific communities. Communities must realize that the new services would be relevant and beneficial to them.
- **Less Interference**
  Existing community systems relevant to their needs must not be disempowered.

Consequence for EC & development partners

Efforts must be made to not finance parallel systems; and to use official systems for channelling support. Existing systems should be used as much as possible.

2. Use new technology

- **Use available, and rapidly advancing technological resources to reach isolated, marginalized or high-risk communities**

Mobile phones, internet and smart cards provide tailor-made services and allow professionals to reach out to geographically isolated or socially marginalized communities. Physical access is a key problem. Technological innovations such as mobile phones and the internet reduce the problems of distance, transportation and time. Therefore, costs also drop considerably.

- **Mobile phones** are actually used in some parts of India for confidentiality and privacy. Young individuals who have contracted sexually transmitted infections are afraid of stigma and do not want their local community health providers (and the whole family/community) to know about it. Medical practitioners belonging to other villages or small towns have one or two hour "phone consultation timings", when such individuals can call them from a private place using a mobile phone. This way, they are able to access essential health services which they would not otherwise.

- **Smart cards** are also an effective device, especially appreciated and used among corporate companies who are engaged in direct health service provision for their staff or communities surrounding their work places. Smart card enables its users to access specific health services and packages, and keeps the health memory of the patient. It thus increases health outcomes.

Consequence for EC & development partners

Creative thinking in applying new technology and in using the latest methods of information dissemination for providing healthcare.

Laboratory Policies: Quality of labs needs to be improved

Regional policies and regulations need to be put in place to ensure minimum lab standards of quality. An enforcement mechanism also needs to be put in place.

Financing Issues

1. Healthcare financing for the needy

- **Ensure that financing mechanisms offer equitable access to prevention, treatment and support.**

To ensure healthcare for those who can least afford it, financing mechanisms should be community-based and in partnership with the private sector.

Replicable model: The Thailand 30-baht card.

2. Tripartite & local funding

- **Tripartite partnership must coordinate funding requirements**

As discussed earlier, the Consultation brought up issues for improving coordination, especially related to funding. Smaller private foundations or donors could directly fund small-scale CBOs, but larger donors must fund and partner directly with larger CSOs. Micro-credit programs have also worked in some situations and should be used as a replicable model.

GFATM must align with national program strategies and simplify procedures, in particular the reporting procedures.

Replicable model: The Bangladesh self-help groups of sex workers, trans-gender people and truck drivers.

- **Fund community-based operational research; invest in promotion of locally adapted self-assessment principles and tools**

Such research would generate much needed evidence of the specific healthcare needs of particular community groups, help in the evaluation of competencies in support of self-improvement, learning and sharing and provide evidence to show what works and what does not.

3. Health insurance

Community based health insurance
Commercial health insurance
National financial schemes (30 baht in Thailand)

II. Disease-specific recommendations

The Consultation looked at specific issues raised in the prevention and control of the three diseases and made specific recommendations for each of them. However, there was an agreement that the strengthening of health systems as a whole was a prerequisite for sustainable progress in the control of each of the diseases taken individually. Many discussions were made on improving their integration into primary care systems, and presentations of successful integration efforts illustrated the importance of this approach.

On the three diseases, the Consultation emphasized the need for community based approaches and acknowledged the results obtained by such approaches in various countries of the Asia Pacific region. These involved the significant participation of civil society organizations, community volunteers and patients themselves. Clearly, one of the important findings of the Consultation was the documentation of success stories based on community ownership and empowerment.

The Consultation emphasized the role of decentralization and political advocacy in raising awareness and mobilizing people for the fight against the three diseases. In the case of malaria, advocacy was mostly aimed at breaking the silence and mobilizing resources; for tuberculosis and HIV, more emphasis was placed on advocacy to reduce stigma and discrimination. The importance of this issue in the Consultation shows how much malaria, tuberculosis and AIDS have become political as well as public health challenges.

The Consultation reiterated the message often heard about the three diseases that tools and best practices exist, they now have to be implemented. The fact that policies, practices and tools are now fully integrated in national policies has given more strength to the "Three Ones"[3]. One specific consequence of this was the general message brought by the Consultation that development partners must support national policies and work with national governments. This message was particularly strong, regardless of the countries participating in the Consultation, because of the specific features of the three diseases.

One effect of the reaffirmation of the principles of the "Three Ones" was the request that development partners not only align with national priorities and plans, but also coordinate their support to avoid duplication and additional administrative burdens on recipient countries. The Consultation implied that the onus of programmatic coordination was on development partners rather than governments, and added that monitoring and reporting tools should be common too and shared by all development partners. It also recommended that supervision and evaluation mission be jointly organized by donors.

Malaria

Several recommendations were made on malaria control. Although it is recognized that stronger government health services can improve access to malaria prevention and care, it was also acknowledged that most of the malaria expenditure was borne by households through purchases made in the private sector. This particular situation required specific approaches by government programs, which had to organize support taking the following factors in consideration.

[3] One national strategic framework, One national authority, One monitoring and evaluation framework

In most Asian countries, malaria is a disease threatening people living in particularly difficult conditions: very poor people in urban and rural areas, tribal populations and people living in remote and hard-to-reach areas. This fact has direct consequences on logistical and supply chain options and cost recovery considerations. The Consultation recommended that malaria programs be adapted to address the realities of the most at-risk populations, and proposed an approach of "universal access" to prevention and care for malaria.

Because malaria is primarily a "household condition", bringing prevention and care services to the communities and the homes requires specific systemic adaptations. However, malaria also corresponds to certain geographic and ecological situations and "regional approaches" have been successful. The Consultation recommended that these two approaches converge as much as possible, with harmonization of primary care approaches and community leaders' advocacy.

On the programmatic and funding sides, the Consultation called for better integration of malaria control in health system strengthening (notably regarding the competence and retention of health staff in rural areas), investment in subsidies for better access to nets and anti-malaria drugs by the poor, stronger advocacy and communication at the most decentralized levels, better education notably for treatment literacy, participation of civil society organizations and improvement of the supply chain.

The Consultation emphasized the importance of CCMs in better integration of Global Fund grants with other sources of financing and in arriving at mechanisms to make malaria prevention tools available free of cost to populations. Mechanisms to reconcile this demand with the need to use private distribution channels in many countries were not studied during the Consultation.

Some very specific recommendations were made during the Consultation, and are detailed in the following pages.

1. Understanding the magnitude of the malaria epidemic

The Consultation felt that at present the extent of the impact of the malaria epidemic in Asia is insufficiently known. The 2005 WHO malaria report stated that in South-East Asia malaria deaths were not reported with reasonable completeness. In India, in particular, the malaria mortality remains poorly known. It was agreed that accurate statistics are missing in several Asian countries. Without more accurate data, Consultation argued it was not possible to design programs and earmark funds to fight the disease effectively. This is also true in tribal and remote areas, where the burden of malaria is not known well enough.

Research programs are necessary to understand the extent of the malaria infestation, and they must include understanding of the socio-economic conditions of populations, customs, knowledge and beliefs about fevers, care seeking behaviors and treatment resistance patterns. Such programs are needed in several Asian countries. In addition, some countries require training programs in epidemiology for their specialists.

Consequence for the EU and other development partners

Financing for research programs on wide range of issues of malaria is needed in Asia. Often, such programs should be regional in scope. The experience of the European Commission with the Mekong Project and that of the Global Fund at the regional level represent important steps in the right direction.

Partnerships with Africa-based organizations working on malaria epidemiology, such as MARA mapping project in South Africa or the Wellcome Trust collaborative research program, could benefit the better understanding of the burden of malaria in South Asia. Partnerships with South-East Asia based organizations could also be useful. Development partners that support these initiatives could consider supporting such partnerships, which would help gain additional knowledge on malaria epidemiology and mortality.

2. Appropriate prevention policy

The Consultation recommended that countries determine the respective roles for Indoor Residual Spraying (IRS) and Insecticide Treated Nets (ITN) for malaria prevention. IRS with DDT was addressed during the Consultation and it was agreed, following WHO guidelines, that it is effective in malaria prevention provided necessary precautions are taken. However, several country presentations showed diverse sets of policies for IRS and different views on the use of long-lasting insecticides. Often, vector behavior and its resistance to insecticide were not fully taken in consideration for IRS. Coordination of policies was found necessary.

Similar issues were noted in use of ITNs. There was no consensus on the use of long-lasting nets (versus re-treatment of nets), target populations, use of social marketing for nets and cost recovery policies. It was suggested that a multi-country study be undertaken to reveal the variations in access to prevention services and commodities. Regional coordination of malaria prevention policy was recommended, based on evidence, monitoring and specific studies.

Chemoprophylaxis and intermittent preventive treatment were not recommended during presentations made at the Consultation, notably by WHO SEARO.

Consequence for the EU and other development partners

Financing of malaria prevention programs is a priority in several countries and regions in Asia. Adequate scientific evidence is required to design strong and coordinated policies. There is room for policy dialogue on malaria prevention policies and need for high level technical assistance and long term financing. As it was agreed that disease prevention and disease management had to be combined and balanced, financial support should not emphasize one component at the expense of the other.

Because of the economic impact of prevention strategies, it was emphasized that EU and partners should carefully review the effect of cost recovery, subsidies and the costs of supply chain and implementation. It was also emphasized that donors request and support high quality nets and insecticides for prevention programs to have the expected impact.

3. Stronger public-private partnerships

The Consultation recommended making strong use of public/private partnerships, both in terms of collaboration with the industry (sponsorship by corporations such as Shell in the Philippines and collaboration with industry partners who manufacture prevention material and drugs) and the private sector of health care delivery.

The Consultation also emphasized the need to create a sustainable market for malaria prevention and treatment products through social marketing. It was however emphasized that the involvement of the private sector must take place within certain rules: respect of the government's guidelines and policies, appropriate level of training, clear deliverable results, participation in the national monitoring and affordability to the population.

Consequence for the EU and other development partners

Development partners should continue to encourage public/private partnerships in malaria control programs, but should make sure that they contribute to the scaling up of programs in an efficient and cost-effective manner. The involvement of rural private practitioners requires specific training and supervision and they need to be recognized and integrated in the overall community health care delivery.

Subsidy on prevention and treatment product prices in the public sector is not an effective form of support, if most of the demand is satisfied through the private sector. Making such products available at village level is important, but requires supply chain support. In remote areas, improvement of access to malaria services can increase utilization of health services as a whole.

4. Addressing the issue of unqualified practitioners and fake drugs

The Consultation identified unqualified health professionals as an important concern in several Asian countries. Many do not have the knowledge required to adequately prevent and treat malaria, let alone communicate proper information to populations. In addition, malaria treatment is often initiated directly by patients without qualified support from drug vendors. Improving the qualification of private providers and village volunteers is essential for better malaria control.

The issue of fake and spurious drugs is a serious one throughout Asia. The Consultation affirmed its support to the WHO prequalification program that allows the selection of products and manufacturers meeting international norms and standards for procurement using funds from the UN system, the World Bank and the Global Fund.

Recommendations were also made to strengthen the network of quality control laboratories in the Asia region, and to provide information to civil society organizations to help them identify fake products. Enforcement of drug procurement rules and stringent quality assurance programs may be a way for NGOs to access cheap and reliable drugs (Delhi Society for Promotion and Rational Use of Drugs, MEDS in Kenya).

Consequence for the EU and other development partners

Involvement of unqualified but trained health personnel can be of service in timely treatment for malaria. However, strict training, supervision and monitoring of these providers must be supported as well for such contributions to be efficient. Unqualified practitioners' involvement in malaria treatment should only be supported if their intervention is part of the national policies.

Support to the WHO prequalification scheme by the EC and international donors is a necessary requirement to ensure access to quality malaria drugs. It was agreed that drug control laboratories needed financial support to be able to face the issue of fake drugs.

One presentation by the Delhi Society showed a procurement approach based on the utilization of tender prices as a basis for direct negotiations with pharmaceutical suppliers. This approach, which yielded good results and is quicker and cheaper than repeated tenders, needs to be examined by development partners to eventually adjust procurement regulations for pharmaceuticals.

Tuberculosis

Asia carries the highest burden of TB in the world, and five countries in the region contribute almost half of the world's cases.

The Consultation emphasized the importance of access of poor populations to early diagnosis and effective treatment, in accordance with the DOTS strategy. Among most at-risk populations, migrants (both internal and trans-border) were identified as one group requiring special attention and support. The issue of gender-sensitive TB control programs was also raised, and it was agreed that more should be done to improve access of women to TB services.

The main agenda for tuberculosis in Asia is about going to scale. Strategies for the detection and treatment of tuberculosis exist in all countries and national programs operate with a reasonable degree of effectiveness. The issue of scaling-up was translated during the discussion into recommendations for better use of decentralization of health services, better coordination between various structures of the health system, greater involvement of private sector providers, community empowerment, mobilization of community volunteers, and strengthening of the referral system.

Contrary to the other two diseases addressed by the Consultation, the issue of access to TB drugs, procurement and supply chain management was less prominent. Governments have often set up systems for sustainable access of patients to TB drugs that should be studied and emulated by programs addressing the two other diseases, or the health system as a whole. One of the strength of TB programs has been the good estimation of drug requirements, effective planning mechanisms and centralized procurement.

The integration of TB services in primary care services would allow harmonization of detection and care services at community level, notably to better cover TB and malaria when needed. Better integration of laboratory services; notably for diagnosis of TB, HIV and hepatitis B and C was also recommended. However, the Consultation acknowledged that successful TB control programs have well trained and specialized health staff, a factor that has to be taken in consideration for integration of primary care services.

The following recommendations emerged from the presentations and discussions.

1. Sustaining funding for TB programs is key

Most countries in Asia are still widely donor dependent for their tuberculosis control programs. The Consultation held the view that the approach to Stop TB is the right one and has proven its efficacy. No strategic change is required in the immediate future, but the introduction of new TB drugs is expected within five years and may require adjustments to the strategy.

Although the Stop TB strategy is not expensive, it requires scaling up and maintenance of the effort. Presentations from several countries showed gaps between funds availability and requirements. For donors emphasis was placed on the importance of supporting the country leadership, aligning with national priorities and plans and respecting policy options. However, it was recognized that critical items have to be financed by the countries national budgets.

Consequence for the EU and other development partners

Support to sustainable funding of the tuberculosis control programs is essential in the medium to long term and financial requirements presented by WHO show that this does not require large funding. The

importance for all development partners to accept a common and standardized reporting system and to coordinate country missions with technical agencies was emphasized strongly.

The Consultation also called for sustained financial support to the Stop TB partnership, emphasizing that it was required to reach the millennium development goals on tuberculosis to halve prevalence and death rates by 2015.

2. Importance of public-private collaboration

Participants in the Consultation agreed on the importance of scaling-up and acknowledged the importance of successful public-private collaboration, which were presented by several countries. Such collaboration can be more successful after a careful mapping of facilities, technical capacities and referral behaviors. It was emphasized that all participants in the DOTS program must abide by the national policies, link with the community services and participate in a single monitoring and reporting mechanism.

The Consultation also emphasized that successful public-private partnerships have to be monitored for performance analysis, referral systems, human resources development and mechanisms of regular Consultation, especially in urban areas. The involvement of professional societies of doctors, nurses, etc. was deemed important for improving and sustaining the performance of private sector partners

Consequence for the EU and other development partners

Supporters of national TB programs must acknowledge the importance of public-private partnerships, and funding agreements must take them in full consideration. It is essential that support to private sector participation recognize the importance of empowering government services with the capacity to enforce national guidelines and quality control mechanisms. It was also recommended that support to TB programs, though specific, could be incorporated within health system strengthening in a more general sense, notably through standardization of referral, reporting and human resource performance. The importance of decentralization was stressed.

Several presentations mentioned the positive effect of financial incentive mechanisms for patients. Financial support to TB programs must be flexible enough to incorporate such innovative approaches, as well as community mobilization, political advocacy and operational research, notably on the issue of migration and tuberculosis and economic impact of TB on communities.

3. Social mobilization and community ownership

The Consultation stressed the importance of community mobilization and ownership for the successful implementation of TB control programs. Presentations from Bangladesh, India, Indonesia, etc. showed the essential role played by community volunteers in the implementation and supervision of DOTS programs, notably because of their excellent outreach capacity. Community health volunteers provide increased access to DOTS, improve patient access to drugs, save time and travel costs, participate in the early detection of side effects and play a critical role in the reduction of failure rates because of treatment drop-out.

In addition, it was found that community involvement and ownership increases social mobilization and decreases stigma. Community mobilization also allows to specifically address some of the aspects of poverty and living conditions that represent specific tuberculosis risk factors. It also allows to better take care of gender issues and access to diagnosis and care by women.

Consequence for the EU and other development partners

Once community-based approaches are part of the national strategy for tuberculosis control and DOTS implementation, international development partners should agree to support them as part of the overall program. Technical support is often required to improve the interaction between the communities and health providers, notably on reporting and interaction with care providers.

4. Strengthening human and technical resources

The Consultation agreed that one of the main challenges of tuberculosis control was the development of competent human resource both in the public and private sectors. Presentations from most countries focused on the need to devise, revise and accommodate curricula for staff, improve the quality and competence of nursing staff and laboratory technicians, conduct regular re-training and quality assessment of human resources in the public and private sectors and motivate staff to perform at the highest possible level. The importance of the availability of qualified staff at all levels of the health system was also emphasized. This included medical, paramedical and laboratory staff in the public sector as well as the private and NGO sectors.

Technical capacity was also seen as an obstacle for the rapid scaling-up of tuberculosis control programs. Presentations emphasized on the need to increase the capacity of reference laboratories to undertake regular surveillance of drug resistance to diagnose MDR TB rapidly and monitor its treatment (involving additional equipment for culture and sensitivity testing). But the strengthening of laboratories at all levels, including simple measures such as the maintenance of binocular microscopes, is also needed. The importance of having a very high case detection rate was emphasized to achieve TB control targets.

Consequence for the EU and other development partners

Support to all aspects of the TB control program is expected from the development partners. Coordination meetings between supporters of TB programs was called for to make sure complementary aspects were supported by donors and partners, within a health system support environment. The issue of strengthening of laboratories was a particularly important one, and was emphasized throughout the meeting.

Development partners were asked to support existing successful mechanisms (for example the WHO supported mechanism for access to MDR TB drugs). They were also asked to support the training of health staff in general and not only for TB control manpower.

HIV/AIDS

HIV/AIDS was one of the main topics of the Consultation and attracted the largest number of presentations and debates. The Consultation came up with a number of recommendations in all the fields of HIV control. As the meeting had a strong emphasis on issues of convergence and health system strengthening, a number of recommendations dealt with these issues.

1. Cross-fertilization between vertical programs

One of the most important set of recommendations pertains to cross-fertilization between the vertical programs: lessons learnt from one program applied to improve the performance of another. For instance, the importance of the involvement of people living with HIV in the successful design and implementation of HIV program has been found useful in TB management. Conversely, the use of community volunteers for better access to treatment in tuberculosis has been successfully

adapted for malaria care, and home based management of TB care has now been used as a successful approach for AIDS patients. Analyzing and documenting this experience is essential for effective scaling up of control programs; the Consultation itself was an opportunity for such cross-fertilization.

2. Health system strengthening

The second set of recommendations related to health system strengthening. In HIV control, health system has to be taken in a wide sense as many stakeholders who intervene in the program are not under the authority or even sphere of influence of Ministries of Health. Even within health systems, diversity of views on the complementarities of reproductive health and HIV services may limit convergence in certain settings[4].

3. Government funding

The third set of recommendations related to government funding and effectiveness of use of external support. The Consultation recommended that the level of government funding for HIV prevention, care, support and treatment be increased as it remains highly dependent on external support in most Asian countries.

4. Creating an enabling environment

The fourth set of recommendations related to advocacy. The Consultation emphasized the need to work with all stakeholders, also at various levels of hierarchy in government administration, in bringing awareness about the issues involved. This, it said, is essential to establish a common approach in dealing with various issues involved in HIV control. The Consultation also recommended for creating an enabling environment for the vulnerable groups.

5. Referral and continuum of care

The fifth set of recommendations related to referral and continuum of care. The Consultation underlined the urgency of strengthening regional networks for providing care. It suggested that existing networks can help strengthen new organizations. The Consultation put emphasis on the continuum of care for mobile population groups through government, professional and non-government networks and harm reduction programs for intravenous drug users.

6. Legal aspects

The final set of recommendations related to legal aspects. The Consultation highlighted the need for information and education for sensitizing people for a law that recognizes high risk groups and their specific needs, and gives them same legal rights as others. The Consultation emphasized that any legislation applicable to HIV and other related diseases should have a consultative process: full participation of all stakeholders at every stage, e.g. civil society and government.

[4] For instance, certain donors disagree on the issue of access to abortion services for HIV positive pregnant women

III. Regional recommendations (Asia-specific & South-South collaboration)

Malaria – Build regional advocacy capacity

- **The Consultation advocated collaboration among Asian countries in the following area:**

Research on vaccines and microbicides
Parliamentary forum on the three diseases
Population and Development
Develop cross-border strategies to address the three diseases

- **Agree on a regional commitment to combat counterfeit drugs and monitor progress on design and implementation of national counterfeit drug policies**

Regional bodies and fora to commit to fight counterfeit drugs and to monitor progress towards design and implementation of comprehensive national policies in this regard in all Asian countries. Special presentations were made on the issue, from WHO.

- **Monitor progress on design and implementation of national lab policies**

Regional bodies and fora to monitor progress towards design and implementation of comprehensive national laboratory policies, in all Asian countries.

- **Develop a comprehensive national policy and regulation on laboratory testing and diagnosis**

This was very clearly expressed in the working group on early diagnosis, especially with regard to malaria and TB, in several Asian countries. The policy needs to be specific about the minimum laboratory standards as well as regulation, and enforcement mechanism among both private and public laboratory services.

Work out specific strategies addressing health care needs of ethnic minorities, MSMs, SWs and IDUs.

Regional Research

It would be useful to do a multi-country study to reveal the variations in access to malaria drugs and other health commodities, such as insecticide-treated mosquito nets. This issue needs to be understood in many dimensions:

1. Universal and free access for malaria prevention and treatment has rarely been a policy that is implemented. While some countries may have a policy of free anti-malarial drugs, it is seldom fully implemented; there are often hidden costs to the patient (consultation fees, diagnosis costs, unofficial charges, prescriptions to obtain the drugs from private outlets rather than the government hospitals). There has always been an underlying assumption that most patients should get their treatment from private pharmacies and other private outlets – even most vulnerable.
2. This was true even when drugs like chloroquine were effective and cost hardly anything.
3. Today, full and effective treatment of malaria, including multi-drug resistant deadly *Plasmodium falciparum (Pf)* cases only cost 2-3 dollars, if provided promptly. Even though it costs very little compared to treatment for other illnesses, one rarely hears commitment by public health specialists or donors, for free or universal access to malaria treatment, even for the most vulnerable groups.

4. Malaria treatment needs to be available and accessible at all time as those with *Pf* malaria can die, such as young children in Africa, between 24-48 hours – this element of urgency and time, needs to be appreciated. In parts of Asia adults may also be vulnerable to rapid deterioration, as those affected are often travelers with low immunity. The children affected in Asia are often those living in remote areas with least access to health facilities.

Once the real costs to patients in different geographic, social and economic settings are understood, strategies to remove financial barriers can be tested, and promoted where there is evidence of success.

India-focused Research

In the case of India it is particularly important to find out what the policy on charging for treatment will be when India implements on a large scale a strategy that includes artemisinin-based combination therapies (ACTs) for treatment (so far introduced in five States for lab-confirmed cases). Also what would be the policy for the World Bank supported program, which is a significant funding source; both for prevention and treatment?

How many persons die of Malaria each year in India? No one knows. No one knows with sufficient precision. We are dangerously working on very vague estimates. All agree – government, private sector and civil society alike – that information and statistics are critically lacking. Hence malaria is called by some advocates a "silent killer". Without more (accurate) data, it is virtually impossible to design programs and earmark funds to fight the disease effectively. Data and research to acquire and disseminate that data is urgently required.

Counterfeit HIV, TB and Malaria drugs: How big is the problem? The problem in Asia seems to be dramatically increasing. Is this a perceived problem or a real problem? And how big is the problem? Some believe this is not based on robust and precise evidence. This would therefore need to be researched.

Market regulation is key to success. Whether it is about drugs, equipment, early diagnostic facilities or other health commodities, there is no way the poor can access effective services that meet their health needs and financial capacities, unless the market is further regulated. The issue of early diagnosis and diagnostic tools is key in this respect. Research is required to bring more attention on the matter, so that it is taken up more energetically by public authorities and health corporations and federations.

How ethical is it to provide free ARV and free TB drugs but no free bednets or anti-malaria drugs, especially when malaria health commodities are much cheaper? It would be worth reviewing ethical issues by comparing what the three national programs offer to patients, at what cost. It would also be interesting to do a comparative study among a few civil society and corporate sector providers to see what they offer for free and what they charge, at what cost? The point here would not be to advocate for free or subsidized services; the point would be to compare cost of services and commodities among the three vertical programs, and to understand and question the rationale for free or subsidized services and commodities.

Engaging in operational research to reduce the crisis of health professionals. India has tried for decades to address the human resource gap in the public sector in rural areas. For different reasons, it has failed in that area. It is vital to identify and disseminate any experience or system that shows ways to improve rural health services. It is also important to study and learn from models of staff retention in other countries, in particular Asian or European countries. The issue here is not just

to research and document what exists elsewhere. The issue is primarily to identify and study what has been working in India, and to engage in operational research. The systems must look at salary and incentives, training and supervision, regular availability of drugs and equipment, among other important issues.

Understanding the heterogeneity of HIV epidemic in India. There have been a few studies which have put forward the heterogeneity of the epidemic in India and the need to know more about the drivers and levels of infection in local contexts. This is crucial in order to design and implement sharper, tailor-made prevention, care and treatment interventions. Without a better understanding of the epidemic at district and block levels, it is not possible to address HIV effectively. Studies on each of the four types of districts under NACP-III categorization (High prevalence; Concentrated epidemic; Increased presence of vulnerable population; Low/unknown vulnerability) would help understand epidemic in India.

Micro-health insurance: Comparative study of 10 different service providers. When trying to work towards universal access to prevention, care and treatment, a key question is whether services will reach people or not, particularly those geographically or socially hard to reach. Another key question is that, even when services can reach people, physically, and socially, will the people be able to afford those less distant services? In this respect, micro health insurance is key to "universal access" since quality micro-health insurance schemes do help in making health services much more (financially) accessible to the poor and excluded. A comparative study of different micro health insurance providers, belonging to different networks, operating at significant scale, would be useful.

Public-Private-Partnerships, on any of the three diseases, in India: What does the experience tell us? Surely, much before the slogan "Public-Private-Partnership" started sweeping across the globe in the recent years, there had been partnerships or joint ventures between public and private entities, to jointly fight HIV, TB and Malaria. So, it would surely be useful to reveal, assemble and compare some of the most effective partnerships that have taken place, on the three diseases, say in the last thirty years. It would also be useful to focus on those which have been working at scale, as we are looking at achieving the Millennium Development Goals, or working towards Universal Access to prevention, care and treatment. In the more recent past, more examples of public-private partnerships are likely to be found in the field of TB.

How to ensure that India's Corporate sector increases its resources for the poor, marginalized and excluded, to fight the three diseases collectively in a more effective manner? Globally, the Global Fund has failed so far to attract a significant share of resources from the corporate/private sector worldwide. From end 2002 till May 2006, the private sector has only provided 3.3 percent of the total funds received by the Global Fund (US$ 166 million out of 5 billion). India's corporate sector can surely do better than this. It does not appear that any detailed research has assessed the actual contribution of India's corporate sector in fight against the three diseases that largely affects the poor and marginalized. However, in a country where 80 percent of the health services are provided by the private sector, it is critical to analyze as precisely as possible, given the magnitude and complexity of the India context, how much both the corporate and private sectors [but primarily the Corporate sector, to narrow down the scope of the research] contribute and reach out to the poor and socially or geographically excluded. Some focus areas for research are:

- Financial volume earmarked to the poor and hard-to-reach
- Types and size of services available to the poor and hard-to-reach
- Provision of low-cost essential drugs and other key health commodities

- Actual coverage/poor patient outreach
- Investment in research for low-cost, good-quality health commodities that can be accessed by the poor
- Role models/examples of localised interventions taken to scale

Studying, structuring and disseminating information on the mail-box applications (patents). Since early 2005, India has become TRIPS-compliant and has reviewed it patent regime and patent law. Consequently, a huge number of applications for patents are now being processed, after remaining for many years in the "mail box". There are some genuine and less genuine applications, with key questions related to innovation –or lack of innovation. This is especially relevant for first and second lines of ARV treatment (though also many other drugs and health commodities), and the future cost, and therefore accessibility, of these drugs. A few civil society advocates are keeping an eye on those applications, tracking those that may be harmful for universal and affordable access to drugs. These civil society advocates badly lack resources, including time. More resources are required. Researchers who could help study, structure and disseminate information, in a very systematic way, would be very useful indeed.

How far HIV programing can learn from TB-DOTS? The TB/DOTS program offers: (i) a simple package of interventions; (ii) a few targets that are monitored regularly; (iii) simplified/ standardized diagnostic and treatment; (iv) ensuring uninterrupted drug supply. Many will argue that HIV is much more complex to address, and therefore HIV programing cannot be as simple as this. Others will challenge how far DOTS is really making a difference and reaching out to the most vulnerable, isolated and/or mobile. However, HIV programing surely can learn from some of the useful, practical DOTS lessons. Looking critically at DOTS may help HIV programing to focus and simplify some of its monitoring tools, and list of issues to monitor. Simplifying the HIV Program may help share more easily a collective sense of achievement. This is required in order to help key stakeholders trust that what they do is useful and that the joint fight against the virus is making a difference [Reducing the number of indicators to track and monitor is likely to help generate focus and confidence. Again TB/DOTS lessons are likely to be useful in this respect].

IV. Recommendations to the European Commission and other stakeholders

European Commission

1. Support effective strategies without restrictions

The Consultation recommended that the European Commission and the member states of the European Union promote more clearly and loudly their support for strategies that have proved effective. This recommendation was particularly related to the issue of marginalized groups at high risk of HIV transmission (sex workers, MSM, injecting drug users) for which other development partners – the US government – provide limited and conditional support.

The Consultation recommended that the European Commission support programs for sex workers and NGO/CGO working with sex workers without restrictions or the type of constraints that are present in the PEPFAR regulations. The same applies to harm reduction strategies (exchange of injection equipment, access to oral substitution maintenance therapy), which have been proven to be highly effective to reduce HIV transmission among drug users, but are not supported by the US government. The same also applies to certain reproductive health services.

The Consultation estimated that the position of the European Commission must be one that is supportive of sound government policies, without moral prescriptions of limitations.

2. Support operation research

The Consultation has recommended a large research agenda and found that operation research was a full component of HIV, TB and malaria programs. Research by local academic and other organizations needs to be supported and its results disseminated. The European Commission, which already supports several research initiatives and joint work by local and European academic institutes, is particularly well placed to support this research agenda. The existing funding mechanisms are not always linked with the support to public health programs and a coherent approach must be found.

3. Adjust calls for proposals to civil society

The conference recommended that community based approaches be supported because of their proven efficacy in the three diseases, especially for marginalized groups having to deal with HIV prevention, care and support. Often, community based organizations find it difficult to access calls for proposals for civil society, as they often do not have the proposal writing capacity, proven track record, accounts keeping competence and reporting capabilities to be strong candidates for EC support. In addition, the amounts they require are often too small to qualify for EC support.

Several mechanisms have been explored by donors, including members of the European Union, to support CBO through "proposal clubbing mechanisms" of various sorts: establishment of a CGO support fund with one large and reputable national organization, grouping of CBO proposals under one "mother NGO" in charge of managing the implementation of the proposal by the CBO, channelling of funds through UN agencies working with CBO, management of CBO proposals and implementation under financial organizations (micro-credit, for instance) supporting the communities.

Calls for civil society proposals should allow advocacy groups to be supported, especially groups working on political advocacy, advocacy for effective decentralization, community mobilization or advocacy for human rights and legislative change. Civil society organizations working on issues of intellectual property and access to essential medicines for the three diseases require specific support as well.

4. Link investment in infrastructure and public health goals to improve physical access

Physical access has been described as a key problem in an important number of geographically hard-to-reach areas in most Asian countries. Improving road and transportation infrastructure cannot be the only answer, everywhere, for each and every village. However, road building contributed to the economic development of isolated areas and has several positive public health effects, as it enables: (i) patients to move more easily and faster out of their villages when in need; (ii) service providers can access villages faster and (iii) supply chain works more effectively and efficiently.

5. Use political clout

The Consultation recommended that the European Commission use its political clout and the combined influence of its member states to advocate at the highest level for sustained financial resources (both domestic and international) towards health MDG, which include specific targets regarding the three diseases addressed at the conference.

Development Partners

The Consultation emphasized the importance of the "Three Ones" as the preferred framework to guide the assistance of development partners. Adhering to the "Three Ones" principles should mean that the national strategic framework is the only one that applies in the country, and preferences or prejudices from development partners should not be considered in the support provided to the national program.

Several working groups recommended that development partners exercise caution and restraint in the recruitment of national staff and pay reasonable salaries. Several participants worried about the "brain drain" of national technical experts, which often starts with employment by development partners.

Global Fund

The Consultation acknowledged the positive role played by the Global Fund in providing much needed financial support to programs addressing the three diseases. Global Fund representatives provided a clear view of the breakdown of support provided to various Asian countries for each of the three diseases and health system support.

The Consultation recommended that the Global Fund simplify its procedures to allow countries to use their national strategies, plans, implementation mechanisms and M&E frameworks without having to create specific approaches, partnerships or indicators for the Global Fund use alone.

The Consultation also recommended that the Global Fund align its supervision/monitoring visits with those of other donors (including the World Bank) so that program officials and stakeholders would not have more than two visits per year from development partners. The Consultation recommended that the findings of supervision missions be shared widely for all to benefit from that.

Civil Society Organizations

1. Acknowledge the diversity of partners' identity

On several occasions, both in plenary and group sessions, it was obvious that a number of persons tend to think in a restricted and one-dimensional way when thinking of individual or groups of development partners, or when relating to the public sector

There is no such organization as just one "Government" or "Government body" that provides health services. The risk of caricaturing the public service of health is unhelpful, misleading and ignoring the complexity of reality, which has to take in consideration a number of layers, departments and even ministries that provide health services[5]. Especially when working at grassroot level, it is vital to understand the large variety of different health services that are, or can be provided by a number of different public actors, departments and so on. Though there is indeed one Health Ministry that shares the responsibility of Health services, and the health of the people in the country, or the State/Province, these services are provided under different structures and lines of accountability.

The same applies to the concept of donor. Considering that all donors are alike is also clearly an unhelpful, misleading understanding and interpretation of reality. Different donors have different values, systems and objectives, even though the majority today works within the "MDG and poverty-reduction framework". In order to make partnerships more effective, it is important to understand the varying values, systems and objectives of different donors. Seeing them as "one block" is counter-productive. The point was profusely illustrated when discussing about effective strategies for high risk groups like sex workers, intravenous drug users and men who have sex with men.

2. Use clear language

Conference participants and the organizations they represent should commit to use clear language when communicating with target groups, within their own organizations or with stakeholders engaged in the fight against the three diseases. Two examples appeared during the Consultation:

Major efforts need to be made by civil society organizations to speak a jargon-free language that the poor - and more and more often rural poor - can understand. The overwhelming utilization of acronyms and ready-made expressions is often more confusing than enlightening.

When communicating with staff, volunteers, partners or stakeholders, efforts must be made to avoid broad, high context language (like "stigma and discrimination"), instead use context-specific language and examples ("discriminatory attitudes of health care providers in the public sector, at primary health care facility level, towards HIV and TB suspects"). Use of high-context language, more often than not, makes it impossible to transform thinking into action or bring about real change in a practical way.

Some words that are used together mean different things and their usage may lead to loss of meaning:

- Stigma and discrimination are not the same thing. Stigma leads to rejection and isolation of its victim and must be combated in the fields of information, culture and societal relations.

[5] For instance, in India, antiretroviral treatment is provided, beside Ministry of Health facilities (at Union and state level) by the Ministry of Defence, the Ministry of Home Affairs, the Ministry of Railways and the Ministry of Steel. Many other ministerial departments provide prevention and care services.

Discrimination is a "positive act" that can often be challenged in court and for which appropriate enforcement of regulations can make a difference. It is much more difficult to fight stigma than discrimination.

- Monitoring and evaluation are not the same thing. Monitoring is an ongoing process of any program. Evaluation happens after the program (or part of the program) is over. Monitoring has to be conducted by implementers of the program; evaluation is better conducted by outsiders.
- HIV and AIDS are not the same thing. HIV is a virus producing an infection that can remain silent for years. AIDS is a syndrome associating various clinical consequences of immunodeficiency created by HIV.

3. Support the national strategy

During discussions, it appeared that some civil society organizations follow an agenda that is not that of the government. This is sometimes true of some faith-based organizations and NGOs with a broader agenda than public health[6]. While it is acknowledged by the Consultation that NGOs should participate fully in the management, implementation and governance of disease control programs, this participation requires adherence to the strategies and values defined in the national strategic framework.

4. Learn to detect and report about counterfeit drugs

Health is not limited to the intake of medicine, however, for a poor patient[7], health service provision is often synonymous to drug purchase and drug intake. The question is whether the drugs one bought is the right one or not, and it would indeed be important to base this on the assessment of a competent medical or paramedical service provider. However, even if the drug purchased happens to be the right one, from a packaging point of view, the next thing is to know whether the drug will be effective or not. One of the reasons why it may not be effective is that it may be a fake drug with hardly or none of the chemicals required. So, in a context where drug intake is a major health practice from a poor patient's point of view, it is important that the drugs s/he takes contain the required chemicals, in the forecast dosage. It is therefore important that civil society organizations, including community-based organizations and self-help groups learn to detect fake drugs, especially for diseases which have previously been rightly diagnosed and the correct drug regimen has been prescribed by a competent health provider, from the national list of essential drugs. It is then important that they report where, when and from whom these fake drugs were purchased so that the counterfeit drug industry can be gradually identified. The next step is law enforcement and requires political commitment from governments. Again, civil society involvement, and quality advocacy work, will help government address the matter.

Foundations

The Consultation acknowledged the important role played by foundations in the response to the three diseases in Asia. The mobilization of financial resources from foundations is important in the fight against the three diseases. However, the Consultation also acknowledged that many foundations work without sufficient consultation with the Government and often pursue an agenda that may not be exactly similar to the national strategy.

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[6] One participant reported that an NGO running a counseling center for MSM made them pledge to abandon all homosexual activity from now on before receiving counseling and support.

[7] This is not restricted to poor patients, however, our target group, primarily, are poor patients

The Consultation recommended that Foundations adhere to the 'Three Ones' principles and realize the important responsibilities they are taking. One issue that was identified in several working groups was that of the "exit strategy" of foundations and the transfer of their activities and achievements to the national government. Such exit strategies must be clearly stated and a closer coordination with national authorities is required to ensure the foundations involvement.

Private Sector Providers

The main recommendation made by the Consultation to private providers was to adhere to the government guidelines, notably treatment guidelines, and to fully participate in the implementation of the national strategy. However, additional recommendations were made on cost recovery: private sector providers participating in the scale-up of programs for the three diseases must be compensated for their work through government subsidies, insurance payments or other methods of funds transfer. Their involvement should not translate in an additional financial burden placed on patients, who generally cannot afford out-of-pocket prevention and treatment services they need.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten UN agencies in a common effort to fight the epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored program, unites the responses to the epidemic of its ten cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.